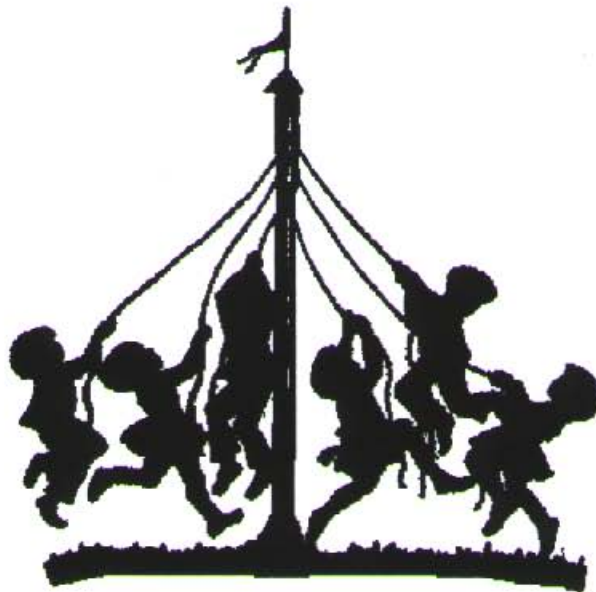


The Michael Sieff Foundation

working together for children's welfare



KEEPING CHILDREN IN MIND

Balancing Children's needs with Parents' Mental Health

Report of the 12th Annual Conference hosted by
the Michael Sieff Foundation
held at Cumberland Lodge, September 1997

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Introduction

The Lord Haslam, Chairman of the first session, opened the conference by calling for two minutes silence for Diana, Princess of Wales. He then welcomed the delegates to this the 12th Annual Michael Sieff Foundation conference, and commended Arnon Bentovim, who had perceived the subject and worked tirelessly as Planning Committee Chairman.

1. The Child's Perspective

Dr. Sheila Adam, Deputy Director of Health Services, NHS Executive, began by saying how delighted she was to be giving the opening presentation at this, the 11th Annual Residential Conference of The Michael Sieff Foundation. In addition she welcomed the theme of this year's conference, since achieving a balance between the needs of children and the needs of their parents who have a range of health problems or disabilities, presents a continuing challenge to Health and Social Services. Sheila felt that developing better ways of working with families, to support them in bringing up their children, must be a key priority as we move into the 21st century.

Background

Any ill health or disability presents difficulties but the problems when a parent has a mental health problem or a learning disability are particularly complex.

Mental illness continues to be regarded with fear and with suspicion. People even with less severe mental illness continue to be stigmatised and discriminated against in all spheres of life.

Child protection services are not always aware of the presence of mental illness in one or either parent. Conversely the services which care for those adults with mental health problems all too often fail even to recognise that the adult may have children, let alone to understand the needs of those children and to begin to ensure that they are met. Although some cope well, children of mothers with depression have well documented problems. In addition we know from both child protection and homicide inquiries that the children of parents with psychosis are

at greater risk of maltreatment during their childhood. There are indications that developmental difficulties and behavioural and psychological problems can persist into later childhood and possibly beyond.

Parents with learning disabilities face doubt and scepticism about their capabilities as parents. But there is now growing evidence that, with the proper support, parents who have learning disabilities can bring up their children successfully. They will often require extra help, offered in a way which recognises their understandable fears of those who work in statutory services.

Similar suspicions and concerns may exist about parents who misuse drugs but again this should not result in their being inevitably regarded as unsuitable or inadequate parents. Additional support though will often be required.

In each case the particular needs of these children must be recognised and understood, and the range of informal and formal services provided to meet their needs, as well as to meet the needs of their parents.

Children's Health

Since the election in May the word "inequalities" has returned to the vocabulary, and concerns about inequalities are central to Government policy direction - in health and elsewhere.

In recent decades, child health has generally continued to improve, in terms of life expectancy and quality of life. Both perinatal and infant mortality rates have fallen and in the last twenty years cancer mortality rates for children have fallen by nearly a half. On the whole children are becoming physically healthier. *The health surveys of children tend to focus on physical health, and therefore we have more limited evidence on psychological health and social well-being.*

But coming back to the theme of inequality, there are also some worrying trends. Despite the fact that improvements have taken place in all social groups, we have seen a widening gap in social class differences as regards death rates, which can be traced back to the 1950s.

In fact, variations in health status between different socio-economic groups have been documented in Britain since the 1860s and are found across the developed world. It is difficult to make meaningful comparisons of mortality rates between countries, although there are suggestions that inequalities are worse in the UK than in some other western countries.

Just to summarise some of this, life expectancy at birth for a baby boy born this year is estimated to be about five years less in a working class family than in a middle class family. Children in Social Class 5 are five times as likely to suffer accidental death as are their peers in Social Class 1. *If we look at this geographically, the health district with the worst infant mortality rate in England has a rate more than 3 times higher than that of the best.*

Government Policy

Evidence suggests that these inequalities are widening rather than diminishing and I think that this will be a key theme for the Government's Green Paper, "Our Healthier Nation", to be published during the winter. This Green Paper, whilst consulting on a range of issues, is very likely to identify children as a priority area. There will be a focus on tackling the root causes of health inequalities such as poverty, unemployment, poor housing and pollution. To quote Tessa Jowell, Minister for Public Health: "Right across society the poorer you are, the less healthy you are likely to be. Inequalities are set in childhood which means that all stages of childhood offer scope for improving health".

In a speech in July 1997 at the Health Strategy Conference she went on to emphasise the importance of healthy schools and the need for a "whole school ethos" in tackling inequality. But she also highlighted the importance of pre-school education in helping to teach problem-solving skills and to promote self-esteem, the intention obviously being to interrupt the well-described link between deprivation in childhood and a range of subsequent problems in adult life.

The programme of work which Tessa Jowell has initiated is part of a determination across the whole of Government to tackle more effectively the problems which our children face and to do this in a way which is coherent and corporate throughout national government and within local communities.

Just to give three other initiatives as examples:

- from the Department of Education and Employment, we have education reforms including a Green Paper on children with special educational needs, later this year;
- from the Department of Social Security, Welfare to Work, including the new deal for young people;
- and from the Home Office, a major new focus on youth justice which will combine a clearer delineation of the responsibilities of both young people and their parents, with an improved youth justice system including a range of new, more effective and more timely interventions for young people who offend.

Parenting

One of the specific cross-Government themes which has already emerged is that of parenting - with proposals including parenthood education in secondary schools; a stronger role for parent education when children are young; and more support for parents. *We are perhaps finally recognising, that parenting is the most difficult thing that most people ever do, and should not be left to amateurs.* Partnership will be essential. We will be looking for joint working relationships with the voluntary sector, as well as the statutory sector, and health and social services will play a vital role in this.

Social Exclusion

In addition, the Government has committed itself to tackling social exclusion. The definition in Peter Mandelson's speech to the Fabian Society last month was - "the people who have lost hope (who) are trapped in fatalism, today's and tomorrow's underclass shut out from society". He said, "Our vision is to end social exclusion, our priority is to redirect and reform social programmes in the welfare state towards that goal, our strategy is to build a broad ranging political consensus for action. There are 5 million families where no-one of working age works; 150,000 people deemed to be homeless; perhaps 100,000 children not attending school. Three million people living in the worst 1300 housing estates expressing multiple deprivation, rising poverty, unemployment, educational failure and crime". A daunting agenda which will require concerted action at a local and at a national level.

Department of Health

There are obviously major implications for those of us working in the Department of Health. We shall need to establish a clear framework within which to pursue the priorities for children and for children's services. We need to continue to improve the health of all children, and to enhance the quality of health and social care which we provide for them and for their families.

This will not be easy. Health and Social Services are already under considerable pressure, with an increasing number of competing demands on limited resources, human as well as financial. Simply having more money is not the answer. We will also need more people with the experience and skills to deliver essential services.

Social Services need to balance the protection of services for children and families, against the increased pressures for adult services, and also to balance the needs for child protection against the needs of families in crisis or with special problems. There is continuing concern about child protection, particularly amongst looked-after children.

Within the Health Service there is the need to balance the provision of services through primary and community health care, with the imperative to focus specialist services on a small number of hospital sites in order to ensure high quality care. There are increasing pressures across the board but particularly in child and adolescent mental health services, and in arranging and funding the packages of health, social and educational services for children with complex needs.

Both Health and Social Services are increasingly aware of the importance of early identification of children with problems and early intervention - we need to use all the resources available for families as effectively as possible from midwives, through health visitors and other members of the primary care team, to the range of specialist health services which are required for a minority of children. Staff who have routine contact with children and their families must be aligned to the range of problems which they may face, including psychological, and emotional problems.

The Department of Health needs to fulfil its role within Government with respect to children, including responsibilities and duties to lead and support. We need to signal to the Health Service and to local government our determination to improve things. We need to provide a clear focus for external organisations which work with and for children and their families and we also need to work closely with the research community. We must demonstrate our belief in the links between investment in the health and well-being of children and wider social and economic benefit.

In closing perhaps I could paraphrase Adrian Falkov, who is speaking later in the conference. *He says that we need to continue to promote better ways of working across health and social services and related agencies to ensure that multiple disadvantaged parents receive the support they need and that their children are provided with an environment which enables their optimum development.* It seems to me a pretty good aim for what we will be talking about over the next 48 hours. In doing this we must address the needs of both parents **and** their children who are, after all, all our futures.

2. The Nature of the Problem - Messages from Child Abuse Enquiries.

Sylvia Duncan, from the Ashwood Centre, Woking, began by saying that for simplicity she would be presenting a joint paper, arising out of a larger joint research project with Dr. Peter Reder from the Centre for Relationship Studies, Riverside Mental Health Trust. The paper was about fatal child abuse and although talking about the death of children was an emotive subject, their task was to take these tragedies and find ways of turning them to the benefit of others. Her paper was presented with that in mind.

The document “Working Together” and its Part 8 refinements published in 1991, set out a procedure for reviewing severe child abuse cases in the UK. According to this procedure, a local Area Child Protection Committee must conduct an agency-by-agency review of any case in which a child dies or is severely injured as a result of maltreatment. The Department of Health consistently receives around 120 such ‘Part 8’ notifications a year. Having observed that parental mental health problems featured in a number of cases, Adrian Falkov was asked to undertake a more detailed study of this issue. We have briefly summarised the findings of his analysis of the files of 100 Part 8 Reviews, looking for indications of parental psychiatric disorder.

He concluded that 33% of the caretakers had shown clear evidence of psychiatric morbidity. In a further 23% there was insufficient information to form a judgement and so the overall number might have been higher.

The main diagnostic categories in the 33 cases were as follows:

| <u>Psychiatric Disorder</u> | <u>Either Caretaker</u> | <u>Perpetrator Only</u> |
|------------------------------------|-------------------------|-------------------------|
| psychosis (other than puerperal) | 9 | 9 |
| depression (other than post-natal) | 8 | 5 |
| personality disorder | 6 | 5 |
| drug dependency | 4 | 2 |
| Munchausen syndrome by proxy | 2 | 2 |
| Post-natal depression | 3 | 0 |
| puerperal psychosis | <u>1</u> | <u>1</u> |
| | 33 | 24 |

He also looked for accompanying psychiatric problems in the caretakers and found alcohol dependency in 4 perpetrators and 1 partner. If the figures are restricted to caretakers known to have been the perpetrator of the fatal abuse, then there was clear evidence of psychiatric morbidity in 25% of cases. The first figures refer to all the caretakers and the second column refers to the actual identified perpetrators of the abuse.

Concurrently with this study, and supported by a Department of Health grant, Peter Reder and I had already started to review a one year sample of Part 8 files, in order to elicit general patterns which might have implications for practice. We are writing up our current study results, in which we have reviewed 112 completed files for the year to March 1994. In 35 cases, abuse had already been confirmed as the cause of death, but in a further 14, we had

suspicions that abuse was also associated with the death. Our project looked at many aspects of the cases and a full report will be published next year under the title of 'Lost Innocents'.

As part of this research study we set out to identify the presence of mental health problems, but faced the same difficulties as Falkov in using information of variable quality, and of interpreting clinical details 'second hand', since some case files did not accurately record symptoms and signs and did not contain details of psychiatric assessment. Therefore, we had to make informed judgements about what we would define as a 'mental health problem'. We decided not to include the notion of "personality disorder", because in our view, this term principally describes relationship problems, not a mental disorder.

Our figures were even more dramatic than Falkov's. Taking the 35 cases in which the caretaker was clearly responsible for the death, fourteen of these perpetrators had been suffering from an active mental health problem at the time they killed the child. For half of them, the problem was significant substance misuse. In addition, 2 other perpetrators had a previous psychiatric history, although they were not currently defined as having an active mental health problem.

Nature of the active mental health problem among 35 perpetrators of "confirmed" abusive fatalities.

| <u>Mental Health Problem</u> | <u>Number</u> |
|------------------------------|---------------|
| paranoid psychosis | 4 probably |
| depressive disorder | 2 |
| post-natal depression | 1 |
| substance misuse | <u>7</u> |
| | 14 (40%) |

Another way to present these findings is to consider all 49 cases, including the ones with strong suspicions of an abuse related death. Since no perpetrator was identified as responsible in the suspicious cases, we needed to look for an active mental health problem in either current caretaker.

In the 35 'confirmed' cases, we found that 2 partners of the perpetrators also showed evidence of substance misuse. In the 14 'suspicious' cases, 4 caretakers in 3 families had a mental health problem, one being recurrent depressions with somatic complaints and the remaining three being ... substance misuse.

The following table presents a little more detail about each case and adds information about previous histories of mental health problems. It also gives you an indication of the type of mental health problems that we identified from reading these Part 8 reports.

Significant Mental Health Problems of Caretakers

| <u>Caretaker</u> <i>(Italics = Perpetrator)</i> | <u>Mental Health Problem</u> |
|--|------------------------------|
|--|------------------------------|

A. Active Disorder in Current Caretaker at Time of Child's Death

| | |
|---------------|--|
| <i>mother</i> | paranoid psychosis |
| <i>mother</i> | paranoid psychosis and alcohol abuse |
| <i>mother</i> | paranoid psychosis (with history of overdoses and other threats to kill herself) |
| <i>father</i> | alcohol abuse |
| <i>father</i> | alcohol abuse |
| <i>mother</i> | alcohol abuse (with history of overdoses) |
| <i>mother</i> | undefined long standing mental illness |
| <i>father</i> | paranoid psychosis secondary to alcohol and drug abuse |
| <i>father</i> | alcohol abuse |
| <i>mother</i> | drug abuse and depression |
| <i>mother</i> | alcohol and drug abuse |
| <i>father</i> | alcohol and drug abuse |
| <i>mother</i> | post-natal depression |
| <i>father</i> | depressive illness |
| <i>mother</i> | drug abuse |

| | |
|---------------|---|
| <i>mother</i> | recurrent depressions with psychosomatic complaints |
| <i>mother</i> | recurrent depressions with somatic preoccupation's |
| <i>father</i> | alcohol and drug abuse |
| <i>mother</i> | drug abuse |
| <i>mother</i> | alcohol and drug abuse |

B. Previous History of Caretaker in Household at Time of Child's Death

| | |
|---------------|--|
| <i>mother</i> | 'mental health problems' |
| <i>mother</i> | post-natal depression |
| <i>mother</i> | psychiatric treatment after murdered 1 st child and episodes of suicidal ideation |
| <i>mother</i> | episodes of depression, overdosing & suicidal ideation; possible alcohol and drug abuse |
| <i>mother</i> | history of overdosing |
| <i>father</i> | 'resolved drink problem' |
| <i>father</i> | episodes of overdosing and psychosomatic complaints |

C. Previous Member of Household

| | |
|-----------------------|--|
| <i>father</i> | alcohol abuse, claustrophobia and 'psychiatric help' |
| <i>father</i> | alcohol and drug abuse |
| <i>mother's cohab</i> | alcohol abuse and mania |
| <i>father</i> | drug abuse |
| <i>father</i> | alcohol abuse |

You can see that the same types of disorders come up with regularity.

Impact on Children.

Though there is research evidence for an adverse psychological impact on many children living with a disturbed parent, the majority of parents with psychiatric difficulties can, and do, care for their children satisfactorily. Nonetheless, it is worth speculating why in certain cases, parental mental health problems appear to raise the risk of physical harm to children. We felt that in many of our cases the caretakers' preoccupation with their own personal needs lead to the exclusion of the child's. This was particularly so for substance misusers, whose life styles were so self-centred that their children's safety and welfare was neglected. It appeared that children were harmed when they intruded into the depressed parents' self-preoccupation. For psychotic parents, the picture we found was similar to that described by others, in that the child was at significant risk when incorporated into their parents' delusional thinking.

Assessment Paralysis

The presence of an adult mental health disorder in some cases led to what we have termed 'assessment paralysis'. Below are two examples of how efforts to establish whether the parent did, or did not, have a diagnosable psychiatric disorder, led to the risks to children being overlooked.

In the first case, a mother had developed delusions that her husband was trying to kill her and that dogs were a reincarnation of her dead mother. She began talking to the child as though she were the dead (grand-) mother. Despite her older child recurrently presenting to the general practitioner with psychosomatic complaints, informing a GP trainee of her mother's delusions and visiting social services to say how concerned she was about her mother's mental health, the assessments that were undertaken were of the mother's mental state and whether she would allow contact from professionals. However, she always appeared calm when the GP visited. The critical opportunity to frame the primary issue as one of child protection was when the mother threatened to kill the child at just 4 weeks old. Instead, the risk to the child was not given the appropriate priority and the mother smothered the child at 20 months.

In the second case, the mother had a history of school non-attendance, anorexia nervosa and stealing during childhood, was physically abused by her own mother and had been taken into care as a 15 year old after setting fire

to her parents' home. She became pregnant the following year and went on to have four children, but the three eldest were placed with other caretakers. At 23 her adult psychiatric history began, with deliberate self-harm, attempting to set fire to her flat and admitting that she wanted to smother her child. Over the next eight years, the mother presented repeatedly with depression, threats to kill her children, herself, her parents or professionals and developed paranoid ideas such as people coming to cut her head off. She twice locked herself and her daughter in the flat and on one occasion was seen at a window brandishing a knife. During this time there were five referrals for domiciliary psychiatric assessments, but each one concluded that she was not showing evidence at the time of a formal psychiatric disorder and there were no grounds for invoking the Mental Health Act. This conclusion was accompanied by a decision that no further action could be taken. The mother eventually drowned her daughter at 4 years of age.

These are two vivid examples of what we have termed Assessment Paralysis. It seems to us that in such cases, two parallel assessments are necessary, one by someone who can see the problems from the perspective of the parent, including an explanation for their behaviour and of what intervention is possible, and a second by someone representing the child's perspective. *However, it needs to be appreciated that children are not at risk from their parents' diagnosis as such, but from their behaviour. If professionals conclude that the parent does not currently suffer from a psychiatric illness and no intervention is indicated, it still leaves the question whether the child is at risk from the parent's behaviour and, if so, what intervention is required for that problem.*

Our study confirmed what has already been put forward by the first speaker, that there must be much closer liaison between adult and child services, and each needs to be aware of the other's responsibilities and relevance. We see this as a need for everyone to 'think family'. Children's services have a responsibility to keep colleagues working with adults aware of child protection issues, and similarly, adult mental health and substance misuse services need to be sensitive to the possible impact of parental problems on children of the family. This has implications for training, service organisation and policy development and we hope that these issues will become part of everyone's agenda.

3. The Psychiatrist's and Forensic Psychiatrist's Dilemma.

Professor Cordess, Professor of Psychiatry, Sheffield University, speaking as a forensic psychiatrist, with psychiatric and psychoanalytic training, introduced a theme of emphasis on the rights of the **individual** by way of contrast with the "think family" ideas of disclosure and 'child protection', which was the main theme of the conference. People in the very vulnerable situations of being either in psychiatric or psychotherapeutic treatment, or in being assessed by an "expert" for a psychiatric opinion, may divulge things that are not in their best interests and requirements of disclosure of this information can convert the psychiatrist's role into one more akin to "social policing". He felt that the power invested in the psychiatrist and the inevitable 'transference' involved, brought with it a responsibility of confidentiality to the patient - and to the accused especially - when using clinical skills to "extract" information. The question is: How absolute is this confidentiality and in what circumstances can it be broken?

The Dilemmas

There are major dilemmas with regard to confidentiality that a psychiatrist and forensic psychiatrist experiences in relation to the wider areas of the family, parenting and children. For this conference I re-read "Rooted Sorrows" (1997) and in it I read Roger Kennedy's account of the assessment of parenting from the point of view of a family, systems and child psychiatrist. I found it quite different from how I see my own function. I assess and report on the history, mental state and personality of **individuals** - and sometimes the couple - and this most often means assessment of personality disorders, which make up the great majority of cases of criminal offending. I give my opinion on risk in the shorter term and (less reliably) for the longer term. Although I make general comments based upon this assessment, about capacities for caring and other aspects relevant to parenting, for example, impulsively violent behaviour - taking account of the reports of others, say a guardian ad litem or nursery school nurse - I do not offer a comprehensive assessment of parenting because it is not my area of expertise. I, therefore, do not usually see the children. I think it is important that a child psychiatrist sees the children - probably together with the parents. The greatest opportunity for making fine judgements of parenting abilities is by seeing how parents are,

and what they do, with their children. I am careful to set these demarcation lines of what I can offer at the time of initial referral - often against considerable pressure - "... No I can't do that; ... I'm not going to see the children; ... I'll see the parents, and I'll report thus far and no further." I have clear professional boundaries in such matters, and more generally I have patterns of practice which are reliable, and are ones which are largely standard amongst forensic psychiatrists - or so I thought. I shall give you just two - somewhat contrary - examples which illustrate that this belief was possibly an illusion.

Case Vignette 1

The Family Court referred a young, rather sad couple whose child was thought to have suffered non-accidental injury. The Court was saying that the child should be taken into care unless the husband 'admitted' that he was responsible for the fractures seen on X-ray. The young mother said that she would 'forgive' her husband if he admitted to being the cause of the injuries. If he did not, then they would have to split up in an attempt by her to keep the child. He awful dilemma was between child and husband. Maybe, she said, he was innocent but the Court had decided that he was guilty and "in denial". The hapless couple were referred to me for an assessment of risk. I gave this couple a version of the preliminary, routine, caution that anything told, by them, to me may then be included in a report to the court. The husband said from the outset, and repeated with great conviction, that since he did not do it, it would be utterly dishonest to admit to it. So I stopped the interview after about 20 minutes and wrote to the Court saying that there was nothing I could do in the circumstances. The Judge disagreed with this approach and tried to send the couple back, but I declined to see them again - unless something had changed in their account. I thought I was being potentially mis-used as an investigator or interrogator - using the position of clinician, and the undoubted power of medico-therapeutic "trappings" - to pressurise this couple into the sharing of information which they had a right - if they so wished - to withhold.

Case Vignette 2

I was instructed by the Defence, in relation to criminal proceedings, to see a young woman who was thought to be "exhibiting signs of Munchausen by Proxy Syndrome", since her child had died, alone, in her company, and four children whom, over a period of years she had been baby-sitting, had suffered suspected, attempted suffocation. The depositions seemed clearly to point to a very high probability of her 'guilt'. When I interviewed her she denied everything but in such a way that convinced me that she had, indeed, been responsible for these acts. During the course of my several assessment interviews I used considerable psychological pressure. This included putting to her psychodynamically informed hypotheses that there were parts of her mind to which, possibly, she did not have access, i.e. which she "split off" or dissociated, and that as a consequence she was capable of all sorts of things which she now denied. In brief, I was taken up emotionally by the case and decided - on the basis of the history and on my judgement from experience of other cases - that this was a case of Munchausen by Proxy.

For the purposes of this talk, I have to question whether my very active and challenging response to this young woman's denial was professionally and ethically appropriate. I judged her to be extremely dangerous. Since her defence solicitor had told me that she had a very good case and I feared that she might well be found "not guilty", and, therefore, released free to baby-sit again for unsuspecting parents, I found myself (uncomfortably) thinking of the case of *W v Egdell* (1990) (see below) and decided to do whatever I could to make sure that she would not end up released into the community. Rather, I planned to negotiate a course for her detention in hospital, but not, I hoped, in prison. The sticking issue turned out to be the question of her "treatability" and of how to treat her. She is now, however, in a secure hospital.

So those were two cases which, as I prepared this talk, I reflected on my attitudes and practice. They focused my mind upon the obvious dilemmas and upon why I had behaved so differently in the two cases. Partly it was because of the more serious nature of the second case, but that does not seem to be a sufficient explanation. I think now that the difference was a - not totally conscious - decision to be socially interventionist for a greater good - which I find problematic to completely justify in terms of principle, rather than in emotional terms.

Confidentiality

There are different thresholds of confidentiality for professional therapists according to our different roles. Child and adolescent psychiatrists and forensic psychiatrist, for example, clearly have different roles, expectations and concerns. We will probably never see dilemmas of confidentiality identically, and I think that this is healthy. I am concerned, however, that the explosion of child abuse reporting in the last 30 years has produced an enormous

change in expectations. Now all practitioners are expected to disclose in an increasing number of circumstances, and think of themselves and their professional roles in a context of willingness to share information relatively freely, which, hitherto, had been regarded as confidential. There has been a rush to change much of the law and a stream of - sometimes contradictory - 'professional guidelines. The most recent example is that of the Sex Offenders Act (1997) and the 'guidance' document - issued by the NHS Executive - wherein the sentence "While it is essential for each case to be considered in the light of its own facts, it is anticipated that the need to protect the public means that the balance will come down in favour of notification". That is, it is no longer the case that only in exceptional circumstances would confidentiality be broken, but quite the reverse. Evidence suggests too that our societal pre-occupation with child sex abuse and its consequences has made practitioners more active in disclosing on unrelated non-sexual abuse matters, for example violence or degrees of neglect.

I am proposing, therefore, that it may be time to stop and think - are we actually on the crest of a tidal wave of excessive anxiety, leading to pressure and policies of "disclosing" all, and, effectively, a practice of "confidentiality be damned"? Have we thought through the longer term consequences of these changes to our professional identities and how we are perceived - by those who might wish to confide in us?

Confidentiality and its breaching is a massive issue in this era of the communications explosion. Anderson (1995) describes the NHS as "rushing down a slippery slope" in breaching confidentiality. His account of the increasingly wide access to hitherto confidential clinical, health and administrative records includes the subject of 'aggregation'. Information becomes much more sensitive when it is aggregated from different sources. Even now anyone who wants to do so badly enough can get access to medical records and what we might naively assume to have been confidential information. In some sense my concerns are akin to examining the stable door after it has been left wide open. Anderson gives examples in the American health care system and in banking and financial matters, of data bases, previously regarded as confidential, having been used to make information public, which has then been grossly misused. Britain, having a centralised health service system, could be open to even greater abuse.

Sharing of information, or good multi-disciplinary working together, can, on the one hand, be seen as protecting the interests of the patient or child, especially when you are "thinking family". Those same activities, on the other hand, can be seen as a betrayal of the patient's (and possibly the clinician's) rights to privacy which could also be in the public interest. Examples abound in "managed care" which includes insurance interests and in a clinician's mandatory compliance with certain "Child Abuse Reporting Laws" in the USA. Most of the guidelines on these clinical matters, at least in the UK, at least hitherto, advise that it is the clinician's duty to preserve confidentiality but that there may be exceptions. The question is, are the exceptions actually becoming the rule? If, for example, I had done some dastardly thing (say, a potentially criminal act) and I wanted to talk to somebody about it professionally, I would probably not go to a doctor if I wished my act to remain 'confidential'. I would be better off going to a priest - certainly - or to a lawyer, or maybe to a journalist. As Bollas and Sundelson (1995) write, "Lawyers still have privileged relations with their clients, priests with their penitents, journalists with their sources, but therapists have allowed their privilege - equally if not more important to the practice of their profession - to be destroyed. (In the USA) with the mandatory reporting laws and managed care requirements, what patients say will now often be used against them."

Roles

At this conference there are people with a range of professional roles who clinically, at different times, wear diverse "hats": Our dilemmas around issues of confidentiality vary accordingly. I shall sketch some of these different roles and attendant areas for dilemma of professionals working primarily with adults. Thresholds for confidentiality differ within these roles but are all to be contrasted to the quite different expectations and practice of the majority of this audience whose primary remit is child protection.

- The Adult Psychiatrist's dilemma - when he is operating in this area - is rather similar to that of;
- the Forensic Psychiatrist's dilemma; each has at least two roles - that of the practising clinician and the medico-legal "expert". In essence, the practising professional has a dilemma of what to divulge or disclose of information gained under an assumption of (relative) confidentiality. As an 'expert', one's role is, apparently, more up front: you are asked to assess a person or family and to report on a specific area of that person's or family's life. This will be made explicit to the person being assessed and seems straightforward. However, especially since there is likely to be a high emotional valency in the subject matter, there is still an unequal - and partly unconscious - imbalance of power, which is open to misuse.
- The Adult Psychotherapist's dilemma (see below). I exclude the child psychotherapist since I am only dealing with the areas to which I am related professionally.

- The Psychoanalyst's or Psychotherapist's (lack of) dilemma. I say "lack of" dilemma because a common psychoanalytic view, as stated, for example, by Bollas and Sundelson is that there is only one standard for a psychotherapist or psychoanalyst - like that of a priest - that of **absolute** confidentiality. There are, in their view, **no** exceptions which should make the breaching by the psychoanalyst of confidentiality of any information pertaining to the patient. This includes, for them, and for many psychoanalysts, any imposed requirement by the Courts or the law. There is precedent for one psychoanalyst being required by sub-poena to attend court to give evidence. She attended court but made it known that she would not comply. The Judge, in conciliatory mode, merely asked the prosecution counsel what he was going to do about it - knowing full well that counsel could do nothing. Courts are clearly reluctant to enforce breaches of professional confidentiality in such situations but in different circumstances the psychoanalyst may well have had to take the legal consequences of her refusal - that is, to be found in contempt of court with the attendant consequences.

A central point for Bollas and Sundelson is that even to allow consideration of a breach of confidentiality is, for the psychoanalyst, to change the essence of transference and counter-transference within the analytic relationship - such as to undermine the whole psychoanalytic project.

You will probably disagree fundamentally, especially those of you who come to this dilemma primarily from a child protection perspective.

Medical Practitioners still have discretion, within the law, whether they breach confidentiality but, hand in hand with more and more guidelines, expectations have changed. Whereas the modern version of the Hippocratic Oath (World Medical Association, 'Declaration of Geneva') includes the undertaking, "I will respect the secrets which are confided in me, even after the patient has died", modern guidance is less absolute; for example, the General Medical Council states that disclosures may be necessary in the public interest (without the patient's consent), for example, where there is "a risk of death or serious harm" (GMC 1992, 1995). Clearly, this is too complex a subject to pursue in detail here, but suffice to say that a useful and necessary distinction needs to be made between the 'right to disclose' and a quite different 'duty to disclose'. As 'guidelines' proliferate - under a guise of helpfulness - which they undoubtedly sometimes fulfil - it is well to remember that a practice which is out of step with their recommendations is professionally highly risky. What has become known as the "Bolam Test" (1957) ensures that, as medical practitioners, we are bound by the views of the responsible body of medical opinion, i.e. the 'guidelines'. The Royal College of Psychiatrists is presently in the process of producing their own guidelines for contemporary psychiatric practice.

Selected areas of Special Difficulty for Psychiatrists

General

Court Diversion Schemes, within which someone is arraigned, charged, and facing criminal proceedings, but mental health intervention is introduced. A court psychiatrist may be asked to interview - for the purposes of unburdening the criminal justice system of someone deemed mentally ill and in order to arrange for psychiatric treatment. There are dangers, however, that the clinician's (psychiatrist's) professional integrity becomes compromised.

Suppression of damaging reports

Egdell (Egdell v W, 1990) was instructed, as an independent psychiatrist, to prepare a report for a Mental Health Tribunal in relation to a patient's possible release from conditions of maximum security. Dr. Egdell made his assessment and formed the judgement that the patient was too dangerous for discharge. The patient's own responsible psychiatrist, on the contrary, was supporting discharge into the community. In what he regarded as the public interest, Dr. Egdell decided to breach confidentiality, since his instructing solicitors planned not to disclose the report on the plaintiff's (patient's) specific instructions. Dr. Egdell - effectively - made his report available to the Home Office with recommendations that the patient continue to be detained. In the subsequent appeal, based upon breach of confidentiality, the Appeal Court upheld his action and ruled that there was a **right** - but, importantly, not a **duty** - to breach confidentiality in such circumstances. Another case, that of R v Crozier (1988) - where a similar "suppression" of a report was opposed by the psychiatrist - was also upheld.

Children at Risk v Parents at Risk

There are many situations where an evaluation and proper response to the risk of children can put parents at risk of excessive interagency sharing of information and disclosure. A particular difficulty is that in which civil proceedings may be followed by criminal proceedings or vice versa. Although the law disallows the use of evidence from civil proceedings being made use of in subsequent criminal proceedings, this does not - at the very least - prevent a more general culture of “judgement” amongst the different agencies based on the information revealed in the civil proceedings.

A particular example is that of assessment of so-called ‘Munchausen by Proxy’ behaviour. The psychiatric assessment in these cases is intimately entwined with the offending behaviour and a report to the court for use in civil proceedings may come perilously close to making a statement and judgement about the appropriateness of future, or the status of ongoing, criminal charges themselves.

Coda

There are clearly different interests represented by our different roles. A day to day example makes this point simply.

A forensic psychiatry opinion was sought by a psychologist working within the extended clinical team in a forensic service. Statements were made by the ‘patient’ concerning abuse of his wife, stepdaughter and others. This information was shared with the referrer who then felt impelled to pass it on to a statutory agency. Further abuse came to light. As a consequence criminal charges were pursued and the ‘patient’ - now ‘criminal’ - was sentenced to eight years. As a consequence the ‘patient’ was lost inevitably to treatment. The ‘criminal’ feels aggrieved (justifiably) at the ‘leaky’ confidentiality of the forensic professionals. His wife, initially ambivalent, now appears, on balance, relieved, although she visits her husband in prison and clearly eagerly awaits his return home. The children, after initial considerable difficulties, (apparently) “thrive”: more subtle feelings of “guilt” etc. are as yet unexplored.

Question: Is this outcome a success? I suppose one answer is that it represents a family “protection” success - although the family are the least persuaded. It is certainly a **therapeutic** failure. (Although it is not impossible that this man may be helped by the prison sex offenders programme, it is unlikely to be sufficient for his considerable therapeutic needs.)

Finally, should we not take an extensive and intensive look at other jurisdictions to learn how they conduct these matters? Certainly some pay far greater respect to the concept and principles of confidentiality than it is now fashionable to do, within psychiatric and related health services, in this country.

A few examples:

In the **Netherlands** a “confidential doctor” system allows the ‘therapeutic’ doctor to be protected - by an intermediary - from requirements of himself informing, disclosing or reporting. (A related model has been used with offender and non-offender patients at the Portman Clinic, London.) Obviously this is not a panacea.

In **Belgium and Austria** a commitment to “absolute confidentiality” has been preserved. However, it is said that recent discoveries and revelations of homicidal paedophilic crimes remained hidden for so long because of this strict adherence to professional confidentiality.

In **Scotland** the Children’s Panels, in **France** “Children’s Judges”, and in **Germany** a very active system of mediation bring different modes of addressing these immensely important issues. These are, indeed, complex dilemmas.

4. The Court’s Dilemma

His Honour Judge Paul Collins, Judicial Studies Board, began his talk by emphasising that in any disputed case involving a child, the law had placed responsibility for decision making firmly with the judge, after taking full advantage of the professional advice which he is given. Sometimes there is too much conflicting advice and sometimes too little advice. However, judges must retain their responsibility for taking decisions without abdicating that responsibility to the professional.

Judges, of course, do not see the average case. We see the atypical, the intractable, and the unsheddable case and so we have a distorted perspective. But these cases are important, especially in the Family Division and the Court of Appeal, who quite consciously set legal frameworks and establish benchmarks for professional practice in a wide variety of areas. These pronouncements are not rules of law, but professionals have to comply with these judgements for their work to be acceptable in court. This in turn sets guidelines for everyday professional practice.

However, it is not simply a question of the court handing down guidelines to the professionals; there is a two way flow of views and information which shapes current thinking. A conference at Dartington Hall in September of 1995, saw judges and mental health practitioners in child care spend two days discussing various aspects of their work and thinking. Both judges and practitioners found it enormously valuable.

Public law cases are the most familiar ones for investigating the mental health of parents; very often the mental health of the parent is at the root of establishing the Section 31 threshold of public intervention. The court has discretion to make such an order, once this threshold is crossed, often depending upon the assessment of the mental health of the parents, covering for example drug or alcohol abuse, a low level of mental functioning, or mental illness which may lead to sexual and physical violence. In these cases there is quite often too much evidence about the mental health of the parents. The Local Authority, the parents and the Guardian ad Litem will often be represented separately by their different experts, all giving evidence about the same problem. Often there is little consensus among these experts and the judge faces a particular dilemma as to which expert if any, he agrees with. Often he will agree with parts of the evidence from more than one expert. In this context the court ought to exercise control at a much earlier stage over the number of experts that are going to be called on all sides, and the number of disciplines in which experts are to be instructed. There are already encouraging indications that this is happening.

I want to contrast these high profile child protection cases with the mass of private law cases, where the judge's real dilemma is the lack of professional help about the mental health and capacity of the parents in the widest sense. These cases, where the dispute is between the parents and often the wider family, concerning where the children should live or what contact, if any, there should be with the other party, far outnumber public law cases. The figures for 1995 showed the total number of public law cases, in all levels of courts, was 17,231 but the figures for private law cases for the same period was 91,637. Private law cases are the poor relation and not enough consideration is given to them but their importance cannot be over emphasised. Untold numbers of children of every age are, or have been, the subject of litigation between the adults to whom they are closest as a result of irreconcilable family stresses. That means that vast numbers of potentially dysfunctional teenagers and young adults are being injected into the life of the nation and I don't need to suggest why an investment into the lives of these children at an earlier stage might be a prudent expenditure of resources.

What is the role of the State in these private law cases? The Children Act provides very clear distinctions. You get public intervention into the lives of children if the Section 31 threshold is crossed. Otherwise parents can either come to an agreement themselves or get a court order determining any particular issue which arises between them. There is an enormous vacuum where children and their families don't qualify for the Section 31 threshold, but they desperately need help. I feel that the court has a heavy duty in all cases which come before it, to satisfy itself about the welfare of the child and that duty, in many cases, cannot be adequately performed without a proper investigation of the parents, who very often have mental health problems, although they may not be serious enough at that stage to justify more formal intervention.

But the level of resources available means that very often only the most superficial information is available to the court. The result of a single meeting with the parents at the office of the Court Welfare Officer, is quite often all the court receives and it usually has to wait 4 months or more for it. The equivalent cost of keeping one juvenile offender behind bars for a year, around £30,000, would have a significant effect on the provision of mental health resources. Of course, I am not suggesting a direct link between expenditure on one and saving on the other, but I am hardly the first to be concerned about the disproportion in the way in which resources seem to be allocated.

I am going to just mention two of my own cases. In one I had too little help and I think I may have come to a wrong decision as a result. In the other case which had no effective case management I was deluged with overlapping and uncoordinated expert evidence that I had to try to make sense of (but I think I did get it right anyway!).

Case 1. A father applied for contact with his 4 year old daughter from a short lived unmarried relationship. The mother was thin, anxious and very intense, and she opposed contact in principle, having complained of violence in the relationship. The Court Welfare Officer had prepared a sympathetic and helpful report, pointing out all the familiar arguments in favour of the child having some sort of relationship with the father. The mother said that the child was afraid of the father. I was very sceptical about this for all the usual reasons, but also because the Court Welfare Officer could not confirm this claim. So I ordered one period of contact between the child and the father at the Court Welfare Officer's office, where the child was safe, but the mother refused. The court then instructed the mother to comply with the court order, but she still refused. I subsequently attached a penal notice to the order telling her that if she still refused to comply, she could go to prison. As she still refused, and while I was away, another Judge imposed a 14 day suspended sentence. The matter finally came before me on an application by the father to remove the suspension. Now, if I don't send her to prison, I am effectively abandoning any prospect that this child will ever see her father in the foreseeable future; the court had already decided that this was in the best interests of the child. If I do send her to prison, it is an awful thing for this woman who is obviously in a very difficult situation and the 4 year old child has to be cared for. The mother called a psychiatrist who said he was treating her for a condition of exceptional and unusual anxiety, apparently produced solely by the idea of the child seeing the father. In these circumstances her whole functioning as a person was destroyed, her psyche shattered and going to prison would prevent her from complying with the court order and would almost guarantee that she would never take the child to see the father.

The father had no expert evidence of his own, and as he was legally aided, he would have had to apply to the Legal Aid Board for authority to have an expert. This would have taken probably a couple of months, during which time the mother would have created all sorts of problems about seeing an expert instructed by the other side. The Court Welfare Officer reconsidered the matter in view of the psychiatric evidence and deferring to the doctor, said it would be wrong to proceed. Since this did not seem to be the sort of case where I could ask the Official Solicitor to act, I thought I was rather stuck. The doctor was obviously trying to help me but I felt that he had been misled by his client. The decision was mine and not the doctor's but I had no clear evidence for rejecting the unchallenged expert evidence in front of me. So very reluctantly I decided not to send her to prison, with the result that the little girl will probably never see her father. I have a nasty feeling that justice has not been done to that child and that lack of expert evidence was at the heart of my dilemma.

Case 2. This case involved a divorced father's application for supervised contact with two daughters, aged 8 and 6, whom he hadn't seen for three or four years, and he was concerned that without regular contact the girls might forget who their father was. The elder girl missed her father and continued to do so. By the time the case reached me it was completely out of hand. He had been accused of sexually abusing the elder child.

The father called the following expert witnesses: firstly, a psychiatrist who had not treated him, but who had been specifically instructed to report. He said that after his therapy in prison and post release therapy, he didn't think the man remained a risk to the children. He then called a probation officer with special training in dealing with sex offenders. She was a street wise and sceptical person who very much doubted the father's claim to be a reformed person. Finally, he called a clinical psychologist, the director of the therapy team who had been running the father's post release therapy, who said that all the indications were good.

The mother firstly called a therapist, who worked with the children about the abuse, who felt strongly that the case had nothing whatsoever to do with the courts. She regarded as unhelpful rubbish, the views expressed by the psychiatrist called by the Official Solicitor, that the children should know their father if only to dispel any ogreish fantasies etc. that they might have had about him. It was a revelation to her when it was suggested that she might have actually thought about working with the children, not just about the abuse, but also about the loss of their father, particularly bearing in mind the older child's feelings. She really didn't think that was significant at all. The mother also called a consultant clinical psychologist who had been instructed only to comment on the mental state of the mother. In fact she found it necessary to go into her reasons why the father's likely rehabilitation was spurious, in order to explain the mother's views which she supported.

The Official Solicitor's psychiatrist said in his first report that these children ought to have some limited, supervised contact with their father. In his second report he changed his mind, due to the entrenched attitude of the mother, which was likely to impinge upon the children and he thought it would be counterproductive.

In the light of this mass of evidence, I had to consider:

- Firstly, what was the father's condition in the light of the therapy that he'd received?

- Secondly, what was the likelihood of the restimulation of the father in the presence of the children and the consequent effect on the children, however imperceptible and progressive?
- Thirdly, would the children regress when placed in this situation, as the psychiatrists agreed?
- Fourthly, the mother had expressed willingness to go to prison rather than co-operate. Was this due to a genuine desire to protect the children, was it a forensic posture or simply hatred for the father, who had ruined her life entirely.

Finally, I had to discuss the practical situation if supervised contact was to take place. Since it would require co-ordination between the father's, the mother's, and the children's therapists, under supervision by someone else having the confidence of all parties. I decided that this was impractical and a recipe for disaster and it just wasn't on.

In the first case, should I have had the power to call somebody in from a list of court experts to give me an independent assessment of the mother? In the second, admittedly extreme case, should the absence of any practical co-ordinated machinery have been a factor preventing me from making the Order, supposing I thought it right to make an Order for all the other reasons? And that leads to the general question; have we got the level of public resource commitment in private family disputes wholly and disproportionately wrong compared with the level of resource commitment in public law disputes?

5. The Community Services Dilemma: Managing Children in Need Services and Community Mental Health

Paul Curran, Assistant Director, Commissioning & Care Management, Lewisham Social Services said that on a day to day basis front line professionals are faced with conflicting and agonising choices between trying to help children or adults with mental health problems. However, he thought that there was much that could be done to resolve these conflicts provided we retain a focus on the family and not on the narrow interests of our professional group or organisation background. He then cited case examples to illustrate the problems.

Case Examples:

1. This story involved a young woman and her 2 ½ year old daughter. One November evening the mother took a taxi to Westminster Bridge and threw her daughter into the river. Miraculously the child survived because a police launch was able to rescue her. The subsequent case review found that the family had "benefited" from extensive help from both mental health and child care services, but that the help was uncoordinated and ineffective. The shortcomings identified by the review were depressingly familiar:

- Professionals who didn't talk to each other.
- Psychiatrists and other mental health staff who barely acknowledged their patient had a child.
- Little understanding of race and cultural issues by anyone involved.
- Narrow professional and bureaucratic perspectives on the needs of the child and the mother.
- Services under pressure and staff ill-equipped to deal with a complex and difficult case.

2. The second example illustrates the fear and conflict that these cases can generate. Here a woman with a very long psychiatric history eventually lost her children who were subsequently placed for adoption. Her anger and distress focused on the children's social workers and their managers to the extent that she made direct threats to the lives of their children. This had enormous impact on the individuals involved as well as the team and provoked strong feelings between colleagues, with the children's social workers viewing the support offered to the mother by the mental health team, as both undermining of their work with the children and condoning the threats and intimidation against them. On the other hand the mental health staff felt that the children's team did not understand their professional role in supporting and advocating for the mother, that she was stereotyped as a woman with a psychiatric history and that there was little understanding of her feelings as a parent who had just lost her children.

3. The final example involved a Nigerian woman with paranoid ideas who was referred to a children's team by hospital staff who thought her children were at risk. The children's social workers thought the mother needed help in her own right and should be sectioned. On the other hand the mental health social workers decided there were no grounds for a section but considered that the children should be taken into care. In theory both groups of staff wanted to stop these things happening but, in fact, they both stood back and argued with each other until, in the absence of any real help a crisis occurred. The woman was then compulsorily admitted and the children taken into care - the worst of both worlds. In my view each service was attempting to define the situation so that it became somebody else's problem, whilst at the same time setting their own thresholds for involvement so high, that only the most serious and critical circumstances warranted a response, thus ensuring the very outcomes they were trying to avoid.

Managing Community Services.

Drawing from these examples he focused on three key themes:

- Responsibility and accountability
- Confidence and managing risk
- Over and under reaction

Responsibility and Accountability

Are our expectations of services explicit? The pressures on children's and mental health services are great everywhere, but reach the highest levels in our inner cities. In both service areas ever greater levels of skill, knowledge and specialisation are required, leading to a still greater distance between them. There will not be any turning back of the clock in this respect, the question is how do we make the right links and connections to avoid the bureaucratic game of pass the parcel. In particular, do service providers understand that co-operation and collaboration are not optional and is this requirement explicit in our plans and contracts?

Do our staff know what is required of them? Do mental health staff know what to do and who to talk to if they suspect a child is at risk? Do children's social workers appreciate concerns about confidentiality and are doctors clear about their duties to children?

Are our responsibilities to service users clear? Are our mental health facilities family friendly? Is there somewhere for children to visit? If we are concerned about the children of a mentally ill parent do we talk to them and tell them what is happening, where they can get advice and why we are taking action?

Confidence and Managing Risk

In managing any high risk service it is essential to acknowledge the fear that front-line staff will experience and even need to stay safe. Children's social workers and others outside the specialist Mental Health Services are not immune to the media portrayal of people with mental health problems as "mad, bad and dangerous". While they should always recognise their limitations they ought to have a sufficient awareness and understanding to move beyond the stereotype and use the specialist knowledge and advice that could be available to them.

Similarly many non child-care professionals do their best to avoid becoming embroiled in a "child protection case". They know the stakes are high, can feel de-skilled and may be fearful of the emotions this kind of work can provoke. Are they, with their colleagues, confident that they are able to judge risk accurately? Have they had access to training and do we know they are competent to undertake these tasks?

Over and Under Reaction

Under stress, services and the professionals within them develop defences to resist demand. Thresholds for receiving help creep ever higher, front-line staff become hardened and unwilling to respond unless a situation is absolutely critical. Recently our mental health services were audited by the District Audit Service. Their main interest was in targeting services at those people severely at risk. They were tremendously pleased to find that we were achieving 85% targeting on the most severely mentally ill I felt that they had missed the point entirely, because you just can't get services in Lewisham unless you are in the most severe circumstances.

I have no argument with targeting resources on those most in need, but we must do this with some sophistication. There are many parallels between the current experience of mental health services and the development of child protection practice arising from the inquiries of the 70's and 80's. *I hope that in ten years time, mental health will not need its own refocusing debate, due to the system becoming more important than the people it is supposed to benefit.*

The people we want to support will often be very resistant to our intervention, actively avoiding our help by cutting through, rather than falling through the safety net. Our services have to be able to reach out to such people, by being assertive and persistent in offering practical assistance and advice rather than waiting to intervene intensively when the situation falls apart.

This experience of receiving little help or support before a crisis and then draconian intervention when it does occur, is especially true for black families. In Lewisham a quarter of the adult population and approaching half of the children, are from minority communities. Black people, particularly African Caribbean's, are over-represented in the mental health system and their children are over-represented in care and on the Child Protection register. If black families and communities are fearful of the intervention of the "helping" professions it is with some justification. This is not to say they don't want help. They have the same expectations and rights as other people, but the help that is offered must be sensitive, relevant and meaningful.

Tackling the problems.

He then outlined those aspects which are important in addressing the problems:

Improving Recognition

A Joint Approach

Developing our Understanding

Improving Recognition

Personal Awareness - Front-line staff have to see when there is a problem and that there is a responsibility to deal with it. Sometimes this relies on an individual and I would like to give credit today to one of our Social Work staff Marie Diggins whose commitment and energy has ensured that at least things are moving in the right direction in Lewisham.

Professional Expectations - Are there people who have a professional or personal responsibility for managing the interface, for providing specialist advice or support, for example the new "named" professional arrangements for child protection in the health service?

Organisational Requirements - Does the issue have any kind of organisational profile, for example it is only within the last year that we have been collecting information about child protection cases involving adult mental health?

A Joint Approach

The issues and problems have to be tackled together - this is not just a social services problem, nor is it solely the fault of psychiatrists. However the blame might be apportioned the solutions will certainly be shared ones.

We need to have in place **common policies**, on confidentiality for example, and **agreed operational protocols** for dealing with referrals. This means people doing things differently - challenging expertise and by definition curbing some professional judgement and clinical freedom. Setting priorities is particularly contentious within the health service but it must be done if resources are to be used effectively.

We need to take a **joint approach to commissioning services**, whether they be for children who are carers or specialist community support schemes for parents who are mentally ill. We have just begun work with the Family Welfare Association and the Lewisham & Guys Mental Health Trust on a project we hope will deal with many of these issues, with funding from the Department of Health and local Joint Finance. These are easier to say than to do and a leap of imagination is often required.

Developing Our Understanding

We must listen to service users. Earlier this year we had a local conference and were able to involve some service users, who made a number of powerful points. The first was very practical, asking why social workers and CPN's needed to visit together when many people couldn't get a visit at all. Dealing with shared problems doesn't mean we have to do everything together and we need to be very clear that we are using scarce resources effectively.

The second point was more fundamental, in that what these people valued and wanted most was practical help, like benefits advice and child care. They did not want to be endlessly assessed or otherwise passed from pillar to post. They did not understand our organisational boundaries or care about our professional roles, they simply did not mind who provided the help or arranged it. They are right - our challenge is to put their interests ahead of our own concerns and focus on helping them and their children get through their crisis and minimise the harm caused by the illness inflicted on them.

6. Speaking Up For Parents

Mr. Peter Harris, Official Solicitor to the Supreme Court, began by saying that his office could be traced back to the medieval Office of The Six Clerks, which in the 19th Century became the Official Solicitor for the Court of Chancery and later the Office of the Official Solicitor to the Supreme Court. The purpose of the office, he continued, was to represent the interests of those in litigation who cannot represent themselves, namely children and people with a mental disability. About 60% of his work was with children and another 10% with parents who are under a disability in family litigation. It was on the latter group he intended to concentrate his talk.

A Person Under Disability

The definition of a person under a disability is given in Section 92(4) the Mental Health Act 1983, and is a person who is incapable by reason of mental disorder of managing and administering their properties and affairs. The emphasis on property points towards Part VII of the Act, and that this legislation gives little thought to the social welfare and care of the person outside the mental health treatment framework. It is therefore quite difficult to deal with residence and contact issues, so we have to resort to rather arcane procedures for declarations in the High Court. The Law Commission has produced a Report on Mental Incapacity which rationalises this situation and Para 2.51 produces what I think is a very sensible and coherent statutory scheme for dealing with these cases.

My role has no particular statutory framework, but is governed by common law and procedural rules relating to persons under a disability. The most relevant of those rules is that "a person under a disability may only be defended by a guardian ad litem". So if someone is incapable of instructing a solicitor or barrister, on their own behalf, then somebody has to do it for them and in children's cases mostly, but not always, that is me. My position in acting as a guardian ad litem is the same as any other guardian ad litem in litigation, namely to stand in the shoes of the person who is under a disability and to supply their want of capacity. This is a proposition which is fairly simple to state, but it is much less easy to put into effect in every case.

Routes To Cases

The first route is from solicitors who can't get proper, or often even any instructions at all. For example a solicitor phoned me and explained that she'd been asked to act on behalf of a young woman, with a child, who had lived with her mother and her stepfather. When her mother and her stepfather died, the young woman who suffered from learning difficulties found she could not manage to look after herself and her child. Also as a stepchild she had no rights to the family home under the Intestacy Laws, so she looked like being homeless. The solicitor was asking for assistance and so we started an Inheritance Act proceedings so that she could make a claim for her family home. At the same time there were proceedings relating to a residence order in respect of the little boy. Sadly, but wisely, the mother consented to the child being placed with a maternal uncle and aunt.

The other main route is from the Court, when it finds itself faced with a person who has self evident problems of mental health. Recently, a Ugandan lady who had lost a husband and a partner through Aids became extremely distressed and depressed when she was diagnosed HIV positive. Her response was to reject virtually everyone, including the professionals, and there were worries about her children. We eventually found a psychiatrist, who had treated her in the past, who managed to gain her trust sufficiently to make a clear diagnosis of her condition. He confirmed that she was unable to act on her own behalf.

Medical Evidence

Sometimes I may be invited to act but quite often I just give initial advice and I am certainly a guardian ad litem of last resort. If there is anybody else who is suitable and willing to act then I prefer them to act as guardian ad litem. However, there frequently isn't any other suitable person, and so I will invariably accept the appointment, particularly if the appropriate medical evidence is forthcoming from a psychiatrist or even from a GP or an approved social worker. Sometimes the patient will not accept that there is any need for a guardian ad litem at all and will be unwilling to co-operate properly.

The doctors usually understand my position and what I am trying to do, though it can raise issues relating to confidentiality. I can always resort to threats if they are unwilling to give me the necessary evidence, by seeking a Court Order and subpoena them to give evidence.

There is a simple questionnaire, agreed with the Royal College of Psychiatrists and the BMA, together with some leaflets which give a simple explanation to the doctor. We also have one for solicitors whom we instruct and indeed one for patients if they are capable of understanding that we are trying to help them. The questionnaire contains a certificate of capacity or incapacity and some questions to elicit the nature and the extent of the patient's ability to give their views.

The Official Solicitors Approach

In my intervention on behalf of the patient I always seek to ensure that the emotional bond between the parent and the child is respected and, so far as practicable, is supported. I also try to ensure that the patient is involved to the greatest possible extent practicable in decisions relating to the proceedings. I regard it as my duty to give an objective consideration to the litigant's views, before giving them my support and that support will be given in every case, save where objectively it appears to me that the views or wishes expressed by the incapacitated litigant are:

- irrelevant to the issues (and consequently inadmissible);
- potentially prejudicial (in the light of medical or other evidence) to the incapacitated litigant's own interests or well-being;
- or are likely to be detrimental to the child or children of the litigant (on the basis that a reasonable parent will not act to the detriment of his/her child);
- so irrational, unrealistic or unreasonable as to be manifestly insupportable.

I try and take full account of all the patient's circumstances and the fact that their competence may be compromised by being under pressure of the litigation. And the objective is to maximise the part the patient is going to play in the life of the child.

I very rarely consent to an order, but I may not oppose it unless there is clear evidence for doing so. This is where there is a certain conflict between the position of the child and the position of the parent. But when I am acting for a parent, I must represent their interests, however slim, and the child's protection and interests are a matter for the guardian ad litem of the other parties. In the majority of cases there is going to be little, if any, hope of her or occasionally him, exercising a parental role.

In many cases the parent is able and anxious to maintain some form of a relationship and we try to make sure that this is pursued. An example is the mother whose child was in the interim care of a Local Authority with a view to a care order for adoption. With the help of a clinical psychologist we were able to persuade the Court and the Local Authority that the child would be safe with the mother under a care order, but with appropriate support. The proposed alternative was adoption and the mother and child would have lost each other.

How Cases Are Handled

I rarely act as a solicitor directly, acting almost invariably through solicitors whom I instruct for the client. This is important, for in many cases the solicitor may have established a relationship with the patient which should not be

interrupted. The disadvantage is, of course, that we rarely have direct contact with the patient, either practically or emotionally.

We do have problems with solicitors being inexperienced in this sort of work. The patient may go to any solicitor, often with very few experiences of dealing with a patient, so they may need clear guidance. If the solicitor proves ineffective in these circumstances, I may replace the solicitor, but the time and cost of instructing another solicitor comes into the consideration. The basic instructions which I give the solicitors run to something like 8 A4 pages and covers all the issues.

In most of the cases of chronic mental illness there is usually very little chance of the parent keeping the child, but there is a rather greater chance where the patient is suffering from learning difficulties. Here there is a need for the earliest possible assessment unless it is clear that the case is very severe and is fruitless to pursue. In such cases it is necessary to appreciate the evidential burden which will be upon the guardian ad litem. So it is very important to get a good assessment by a clinical psychologist in cases of learning difficulty and a psychiatrist where mental illness or disorder is involved. We particularly need to be aware, in taking these cases, of the ethnic and cultural issues which may overlay the disability. You also have to be aware of other disabilities such as a person registered blind and indeed when the mental health problems are complicated by the social problems of alcohol and drug abuse, the dysfunctional family and any abusive relationships with either a husband or boy friend.

The story therefore which I have to tell is regrettably usually rather a sad one. Cases tend towards the extreme because usually social services and community health services try very hard to support the family and consequently I only tend to get involved in cases where the outcome may well be inevitable. You may feel this is a rather despondent presentation of the Official Solicitor's work. It would be wrong if I left you with only that impression. In these sad cases, it is important that the issues are approached both with compassion as well as objectivity. On the one hand, it is wrong to raise the hopes of a grieving parent unrealistically and on the other, it is vital to ensure that every reasonable prospect of keeping the child or maintaining the relationship is pursued. At a very basic level access to justice, as well as a right to family life, is a right in law and a fundamental human right which must be protected.

The Voice of The Parent

Sometimes the Court cannot entrust a patient to take care of a child but the patient cannot accept this. The patient may feel betrayed by the Official Solicitor if an application is not contested. On the other hand, sometimes the patient won't want anything at all to do with the proceedings or with the child and avoid all contact with me, my representative solicitor and the doctors. But very often the patient does have an insight that she cannot care for the child and wants someone of whom she can approve to do so on her behalf, a family member or a good foster parent. Usually she wants to maintain contact and, most importantly, wants the child to know that it is still loved. Even in the most hopeless cases, giving a patient a voice, speaking up for the parent is as important as resisting the application of the Local Authority or relative.

That is what the Official Solicitor is there for and our various duties are taken very seriously and I can assure you they are discharged diligently.

7. Parental Mental Health: Sensitivity to the Needs of Children.

Professor John Cox, Head of Department of Psychiatry, Keele University, and Dean of the Royal College of Psychiatrists, claimed that his talk could equally have been entitled Perinatal Mental Health, where his clinical experience and research over the last twenty years had been. He is also Director of the Perinatal Psychiatry Service, which includes "Charles Street" the first specialist perinatal Day Hospital in the country.

He based his talk mostly on slides which illustrated the considerable knowledge now available within the field of Perinatal Mental Disorder. He emphasised that at the present time proposals to improve the services for a Postnatal Mental Disorder need to take into account the problems of delivering any Community Mental Health Service because of overcrowding in acute admission wards and excessive managerial constraints affecting Consultant's morale.

Since the 5th Century BC, physicians have given intermittent attention to the psychiatric disorders which follow childbirth. Hippocrates speculated that puerperal psychoses might have a physiological cause such as milk being diverted from the breast to the brain. Only in the mid 19th century, however, did French Psychiatrists Marce and Esquirol provide more detailed clinical observations and drew attention particularly to the distinctive features of the puerperal psychoses. Esquirol said that many such mental disorders were not recognised and that many sufferers remained undetected at home. The name of Louise Marce is honoured by the Marce Society - a remarkably successful multi-professional society bringing together researchers and clinicians within the field of postnatal mental disorder.

One of the interesting aspects of Perinatal Mental Disorder is that any discussion of aetiology includes physiological, psychological and socio-cultural factors. Breen, for example, regarded childbirth as a continuous process which resulted in irreversible physical and psychological changes. Psychoanalysts have drawn attention to the intense identification that occurs between mother and baby as well as with her own mother. If these relationships are hostile then this may interfere with the ability to be a "good enough" mother herself. In one of the early studies carried out in Edinburgh (Cox et al) it was found that the absence of a mother through earlier death increased the likelihood of severe postnatal blues immediately after delivery and several such women said they felt closer to their own mother and could understand more fully what she had experienced during childbirth. Neuroendocrine triggers are also of particular importance for mental disorders when they occur within two weeks of delivery.

In a more recent controlled study from Stoke on Trent (Murray et al) we found that women who gave up work reluctantly were more likely to develop postnatal depression and to have had a more conflictual relationship with their own mother. The point prevalence of postnatal depression at three months was 13%. A particular interest of the speaker was the relationship between social support and postnatal depression as expressed through postnatal rituals, including naming and baptism ceremonies as well as the six week "check-up". In Jamaica there is a period of ritual seclusion which is particularly intense for the first nine nights following childbirth. In India the postpartum women were regarded as impure for 40 days when she and her child would not come out of confinement. Amongst present day Chinese people the custom of "Doing the Month" continues when the mother rests, is looked after by her own mother-in-law, eats chicken and should not be blown by the wind or cry - or resume sexual relationships with her husband. The end of the month is celebrated by the bringing of gifts. Christian baptism is now a less common naming ceremony; yet in Uganda not giving a name to the baby could result in the parents being taken to Court for causing such social disadvantage.

In Western society there is more role ambiguity, lack of social support and, in more recent years, lack of status attached to the role of mother. Social Anthropologists have argued that there is therefore greater discontinuity between generations which results in "Breaks in women's knowledge" (Fitzgerald) leaving a young mother disadvantaged and de-skilled.

In most published studies the frequency of postnatal depression ranges from 9% to 15% or more. In our Edinburgh study for example, 13 of 103 women at five months post partum suffered from a continuous depression since childbirth, and yet a further 17% had milder depressive episodes. Interestingly the children of the women with milder depression showed the most behavioural problems subsequently; 50% of depressed women remained depressed for at least a year and the failure of Community Care Services to recognise and treat adequately sustained depression was notable. The reasons included an assumption that mood disturbances in the puerperium were "just the blues"; reluctance to treat because of an inappropriate concern that anti-depressant medication was always contra-indicated in a mother who is breast feeding, the mother's reluctance to disclose her symptoms and not to comply with medication, as well as the limited availability of psychological therapies such as counselling and cognitive therapy. Whilst the treatment of a moderately severe postnatal depression can be carried out by General Practitioners and Health Visitors, this is unlikely to occur if a specialist perinatal service within a Secondary Psychiatric care is not also in place. The clinical features of postnatal depression, whilst similar to depression, at other times is nevertheless frequently characterised by excessive anxiety about the baby, self-blame relating to her competence as a mother, pre-occupation with aggressive impulses towards herself or the baby, suicidal thoughts and a fear that the baby might be harmed. The loss of libido and disruption of the marital relationship is a further difficulty which is linked to the adjustments occurring at that time as well as to the reduction in sexual interest particularly characteristic of the six month post partum period.

Several studies have shown the effectiveness of anti-depressant medication as well as of non-directive counselling and, more recently "cognitive counselling" in the treatment of Postnatal Depression. In studies carried out by Lynn Murray, non-directive counselling carried out by a Health Visitor was as effective as that carried out by a specially trained psychotherapist - findings which would suggest that in the puerperium the specific contribution of a female health professional to provide support and individual attention is particularly important. It could be that this

professional worker provides a compensation for the lack of esteem enhancing supports formerly available within families.

Several others, including Kendell and Jenkins, have drawn attention to the specific possibility that postnatal depression is one of the few disorders which can be prevented. By recognising high risk women at an ante-natal clinic (i.e. those who have had a previous puerperal psychosis, previous psychiatric disorder, and unstable relationships) and making available appropriate support, education and prophylactic medication the likelihood of a postnatal mental disorder occurring (which can be one in four) is reduced substantially; our experience suggests reduced to one in seven. The widespread usage of screening scales such as the Edinburgh Postnatal Depression Scale has also encouraged primary care workers (Health Visitors and General Practitioners) to screen for PND. This procedure is now encouraged directly by Health Visitor Managers and several studies have evaluated this procedure and shown a pronounced effect on reducing the severity of depression at that time. (Gerrard et al)

Of particular importance arising out of such research is the known adverse impact of post-partum depression on the mother/infant relationship and on "attunement", as well as evidence that postnatal depression is associated with later onset behavioural disorders particularly in five year old boys (Sharp et al).

Services

The optimum services for the management of perinatal mental disorder were outlined which included Mother and Baby Units as well as a community service based at a Day Hospital or closely linked to a generic Mental Health Resource Centre and to specialist Mental Health Nurses. Experience has shown that Health Visitors will only continue to screen for, and initially treat, postnatal depression if they have easy access to this more specialist expertise.

Foreman has usefully summarised the impact of parental mental disorder on children using the following categories:

- (a) The mother as **agent** in child psychopathology by causing impaired attachment, distorting child development or impairing her ability to protect the child from adversity; the known relationship between postnatal mental disorder and Infanticide as well as with non-accidental injury.
- (b) The child as trigger for maternal psychopathology. The birth event whether regarded as physiological or social event increases the risk of postnatal depression three-fold and of puerperal psychosis by at least fifteen fold.

Studies from Australia have shown that child temperament, as expressed by a crying baby, can result in humiliating experiences for the mother which then provokes a persisting mental disorder. Marital intimacy may also be impaired by such temperamental difficulties.

The recent survey by Falkov found a reluctance to identify parental mental disorder (even when severe) and to treat it adequately - and that this neglect may have resulted in fatal, or non-fatal, child abuse.

He concluded by emphasising that Child and Adolescent Psychiatrists needed not only to have identified parental mental disorder but to ensure that it is thoroughly treated. It cannot be assumed for example that identified parental mental disorder (such as postnatal depression) is treated energetically by General Practitioners - and adult psychiatrists may regard it as being insufficiently serious in comparison to other disorders. Undoubtedly Child and Adult Psychiatrists therefore are **both** required to know more about each others disciplines and to co-ordinate more carefully within an overall Perinatal Mental Health Service.

The extent of Unmet need can be readily ascertained by knowledge of the number of delivered women in a given population. Oates for example has succinctly summarised this approach: - if there are five thousand deliveries a year then there are at least 500 women with PND, and between ten and twenty women requiring admission to a mother and baby unit. My clinical experience suggests that a part-time Consultant in Perinatal Psychiatry is necessary to lead a comprehensive Perinatal Service for this size of delivered population. A Report from the Royal College of Psychiatrists and the Department of Health recommending optimum facilities for such a service is eagerly awaited.

Child and Adolescent Psychiatrists are encouraged to continue their training in Adult Mental Illness at a Specialist Registrar level and to arrange joint meetings between the Faculties of General Adult and Child and Adolescent Psychiatry.

It was recognised that the field of Perinatal Mental Health has become an area of specific expertise which draws on a variety of health professional competencies and which specifically requires the co-ordinated skills of Adult and Child Psychiatrists as well as specific training for General Practitioners, Psychologists, Social Workers, Health Visitors and Mental Health Nurses.

8. Parents with Learning Disabilities and their Children, and Children whose Parents have Learning Disabilities

Professor Sheila Hollins, Department of Psychiatry of Disability, St. George's Hospital Medical School, University of London, is an adult psychiatrist in a community based service for people with an IQ up to 70. She stressed that in talking about people with learning disabilities she intended to remind people about the similarities and differences in their needs. Sheila also stated that the point made by John Cox, about child psychiatrists and adult psychiatrists not knowing enough about each others work, applies equally to adults with learning disabilities. She was pleased that the conference programme included learning disability, and she intended to illustrate that such people are subject to the same depressions and other mental disorders.

Learning Disability

Learning disability means having impaired social functioning, which affects development into adulthood. Anyone with learning disabilities can request a Social Services led needs assessment, to consider both health and social care needs. Typically this includes consideration of any support needed in accommodation, employment, self care, diet, leisure, transport, finances, relationships and health. A pregnant woman with learning disabilities should have her own pre-natal support needs assessed, including any anticipated needs with parenting. Preventative approaches to support adequate parenting should ensure that any agencies involved with either parent or child are in regular communication.

I have taken three cases to illustrate certain important issues.

This first example raises the importance of shared care and also a human rights issue.

Since leaving a special boarding school, a 24 year old single woman had lived for 3 years in a hostel for people with moderate learning disabilities. She attended a special day centre and special clubs and also spent a weekend with her parents each month. The parents noticed her pregnancy at about 6 months and they removed her from the hostel. A healthy baby girl was born, and the family was rehoused by the Housing Department. Although her parents taught parenting skills to their daughter, and despite her being capable of learning to provide physical care under supervision, the mother showed no empathy for her child and the grandmother was the primary attachment figure. The mother wanted to return to the hostel but the grandparents wanted her involved in parenting so that the child would know her mother. The presumed father of the child had a mild learning disability but the grandparents asked that he was not told about the child.

The second example raises issues about the attitude of mainstream children's services towards a mother with learning disabilities, their low expectations of her abilities and of any specialist support which could be provided. It also shows how an assessment without appropriate specialist input can lead to lack of remedial help.

A 35 year old single woman has 2 children, a 17 year old son who has a job and still lives with her, and a 6 year old son with a severe learning disability who is hyperactive. When he was about 4, Social Services became concerned that his learning difficulties were because of emotional neglect, and the mother and child were assessed in a Family Resource Centre over several months. The staff there had no particular expertise in working with people with learning disabilities and the mother's own support needs were not fully assessed. Her older son who had now left school, remained in their flat 5 miles away and looked after himself. He had previously played a significant role in caring for his brother. Following a recommendation by the Court the mother's own needs were properly assessed and a multiagency support package was agreed for the family unit, funded by Social Services but with specialist health and social services involvement. Some of the practical outcomes for this mother included rehousing to a safer environment where her child was easier to care for, a welfare benefits check which increased her weekly income by 30%, daily help with housework and childcare, regular respite care, and parenting guidance tailored to

her own cognitive and emotional needs. The role the maternal grandmother and aunt play in supporting the household has also been recognised.

The third example shows the importance of recognising mental health problems in people with learning disabilities. It also raises a human rights issue, and emphasises the importance of separate advocacy for the mother to ensure her case is heard even if the ultimate outcome is unsuccessful.

A 42 year old woman, with a borderline learning disability, gave birth to her sixth child who was immediately removed without warning and placed with foster parents. Previous children were all taken into care during early childhood. She had a presumed learning disability, a personality disorder and previous convictions for grievous bodily harm. She had had a stable relationship for 5 years and no recent trouble with the police. The loss of her child at birth led to irreparable breakdown of relationships with the child's father and the mother angrily grieved both the baby and her partner. Social Services were blamed for her situation, and she took no responsibility for having kept her pregnancy secret and for Social Services mistrust of her. When the infant was 3 months old the mother was allowed twice weekly supervised access visits. At 8 months the Court agreed to residential assessment in a specialist mother & baby unit, but the placement broke down after 5 days because of her unstable personality, not because of any learning disability.

In a recent audit of sudden infant death in a London borough, many of the mothers were found to have learning difficulties. Although further study is needed to identify preventative action, this raises questions about the mother's preparedness for parental responsibilities. Given the greater risk of earlier death for adults with learning disabilities themselves, which doctors believe is due to a failure to recognise signs of ill health and to seek help, this may suggest a proactive approach to health care is indicated. Poverty could also be implicated.

Issues Identified

- Mothers need a 'partner' to help with child care. Shared care with grandparents or foster parents is an option.
- Parents with learning disabilities may have support needs of their own for which specialist learning disability services may have a key contribution to make.
- Multiagency support requires commitment to the needs of both child and parent. A named co-ordinator is required.
- Learning disability includes a wide range of disabilities and the label itself provides no information about capacity for parenthood.
- Mental health problems can also occur in those with learning disabilities.

We are now seeking to develop a co-ordinated approach to supporting similar family groups, recognising that inter - generational, intra - agency and inter - agency collaboration may be necessary, but striving always to keep the child and the parent in mind by recognising both their individual needs and their identity as a family.

Dr. Sue McGaw is a Consultant Psychologist, working in The Parenting Service in Cornwall with parents with borderline learning disabilities, i.e. having an IQ between 55- 85. This level covers 16% of the population. She emphasised that we tend to know those parents who are not coping with crisis situations but what about the main population of parents who are not managing? In addition we don't actually know about those parents with learning disabilities who can actually manage very well. We are estimating that within the UK that we've got perhaps a parent population of at least 250,000 parents in this category. In her Special Parenting Service, she aims to obtain much more knowledge about these unknowns and use this information to aid those parents with mild learning difficulties to better look after themselves and their families.

The Special Parenting Service.

It has a multi-disciplinary team comprising a clinical psychologist, a clinical nurse, an occupational therapist, two assistant psychologists and a secretary. We cover the following types of work: Assessment, Parenting Training, Professional Training, New Resources and Research

There is a lack of understanding across professionals regarding the parents' ability to learn parenting skills including a relationship between parental knowledge, skills and practice. We also have both formal and informal parent training plus a variety of programmes for the needs of these parent groups. Professionals often say that they

are not trained to do this type of work and workers in the learning disability sector often lack specialist knowledge in children's services and vice versa. The resources presently available do not meet the needs of parents since they do not properly target this particular parent population. There has been very little done on skills teaching and very little research done on the long term effects on children whose parents have a learning disability.

I will make one or two points from the research. Deliberate abuse is rare from mothers. Usually if there is reported physical abuse it is usually by the mother's partner. If we know that a child has been abused by a mother, then it is usually because they have been badly stressed by a situation.

In 1982 Shilling looked at the high incidence of children, between 15% and 50%, removed because of neglect. The discrepancy between the mother's knowledge, skills, experiences and resources and the children's needs is a significant factor in abuse. As Sheila mentioned the best predictor of abuse and neglect is the absence of societal or familial support. We know is that if a mother or father has a partner who doesn't have such a high IQ level, but who is good at parenting, then that is the best predictor we have that the children will prosper.

We know from research, in particular a paper by Helfer on the perinatal period, that many people who have been maltreated themselves, have difficulty relating to their children. Quite often they don't speak to their child through their senses, but during the perinatal period we have an opportunity to stimulate parents and correct this.

We also know that where mothers and/or fathers are abusive or neglectful, we do not necessarily have their children removed if they: -

- are willing to attend training
- they do not have additional problems, e.g. alcoholism
- have sufficient support

Looking at the theme of mental health, the important variables are:

- childhood abuse related to poor social adjustment and high anxiety
- childhood neglect related to affective disorders
- poor self-concept

Many parents don't know what the term self esteem means, and therefore they don't know how to raise their own self esteem. A study on the fathers has not yet been carried out.

Some ten years ago, the main emphasis in assessing parenting was to examine two specific aspects, namely:

Primary Child Care: - Physical Care, Affection, Security, Stimulation, Guidance/Control, Responsibility, and Independence.

Child Development: - Infant Stimulation, Self Help, Motor, Socialisation, Cognitive and Language.

However, these two domains alone provide insufficient information about the difficulties experienced by parents with learning difficulties. The model that we have developed in our service takes a practical approach to parenting - assessing the parents ability to cook, shop or clean, and to do all those necessary things to raise their child in a healthy environment. Our assessment involves the **Parenting Skills Model:** - Parents Life Skills, Practical Intelligence (self-help, home-living, independent living), Social Intelligence (social skills, language skills, academic), Family History, Support and Resources. This model has been extended to look at socio-economic issues which affects all parents and what they bring to parenting when they have a child.

Muti-Dimensional Parental Skills Model

Intellectual Functioning & Independent Living Skills

Problem Solving Skills
 Logical Sequence Skills
 Decision Making Skills
 Organisational Skills
 Practical/Social Skills
 Intellectual Functioning

Support and Resources

Specialist Services
 Community Facilities
 Employment
 Family Support
 Transport
 Housing

Family History

Lifeskills
 Stimulation/Learning
 Security/Permanence
 Mental Health
 Physical Health
 Nurturing

They bring the history of their own nurturing; their physical and mental health issues; the security of permanence that they had during their childhood; the stimulation that they received and their lifeskills, which is so important in

parenting. The difference with our parent population is that they have additional problems on top. So even though they may be from a similarly impoverished background they have low intellectual functioning, are very vulnerable to poor patterns of social skills, and their organisation skills are under-developed. These parents can't do many simple things and their lives can spiral downwards as a result.

We try and help with decision making skills and problem solving skills. Logical sequencing, to know how to receive and follow advice and how to implement it, is very important. Without transport, they can't get to the supermarket and they can't easily go the doctor when their child is ill. They are often unemployed and impoverished. Community facilities exist but there aren't many specialist services to help put all of this together.

We will publish at the end of this year a parent instruction manual to pull all of these factors together. Thus we provide a range of services, looking at basic parenting on the one hand and on the other hand looking at the needs of parents themselves, with the emphasis on parents gaining an insight into their own needs. Parents are taught the social impact of this material which often enables them to take control. Showing them what to do makes a real impact and it enlightens them so that they can do things for themselves. This then transfers to the parenting of their own children.

Home Based teaching programmes combined with group programmes have a great impact. We know that many of these parents take on board new knowledge and transfer it to other parents so that they better understand what they should do. However, it doesn't necessarily transfer the skills which we try and teach. Practice will be affected by environmental factors including their own history and experiences as well as their ability to maintain and generalise skills.

Throughout our programme we use one or two selected cartoons for each family, to raise questions in their minds about what the cartoon depicts in its relationship to real life situations. Often this recognition helps the parents to help themselves and their children.

Our findings are that:

- "Off the shelf" parent programmes are limited
- Informal support is insufficient
- Early intervention is important
- A combination of home-based and centre-based programmes are the most effective interventions
- It requires a co-ordinated inter-agency approach.

9. Child Protection and Adult Mental Health: Are they Conflicting Agendas?

Dr. Danya Glaser, Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital for Children NHS Trust, introduced her presentation about emotional abuse which she split into two aspects: firstly a study of some families, and secondly a look at the nature of conflict between the needs of adults with mental ill health and their children's needs and to look at child protection when those needs are not fulfilled.

Emotional abuse refers to the parent-child relationship, rather than to an event in a child's life or a series of events or single interactions. It is a description which characterises the relationship and which is either there constantly or recurs with monotonous irregularity, and includes omission as well as commission. It differs from other forms of child abuse in that it requires no physical contact between the adult carer and the child and it is actually or potentially harmful. The abuse threshold is reached when the viability of the relationship, which is characterised by these interactions, is questionable without some form of intervention. This clearly does not necessarily mean removing the child.

Research Background

I wish to refer to the study "Emotional Abuse: Suspicion, Investigation and Registration", carried out by myself, Vivien Prior, and Margaret Lynch. The three main aims of the study were to ascertain:

- a) the length, time, and nature of prior concerns about the children on the Register for Emotional Abuse,

- b) reasons for registration under the category of Emotional Abuse, and
- c) sequelae and possible benefits of registration.

The rate for registration for Emotional Abuse was 24% in 1996, in those Authorities jointly registering under the categories of Emotional Abuse and another category.

The research sample comprised children who were on the Child Protection Register, under the category of Emotional Abuse, on the 31 December 1994 in 4 Local Authorities selected to reflect rural, suburban and urban populations and all of which had different registration rates both for Emotional Abuse and for other types of abuse altogether. There were altogether 94 children in 56 families, indicating that in some families more than one child was on the Register. The data was gathered from minutes of child protection conferences, with names removed, and also by interviewing the social workers or their managers.

Findings

The characteristics of the sample were interesting in firstly showing that the age range of children, 56% boys and 44% girls on the Register for Emotional Abuse, was from 0 to 16 years, i.e. some children were put registered at birth. Secondly, the mean age of these children was 7 years and the mode 9 years. The ethnic representation varied according to the Local Authority's composition of population. It appears that emotional abuse occurs across all family sizes.

The particular aspect of the Findings on which I wish to focus, is the reason for Registration. Using the "significant harm" concept was helpful, in that it divided the ill treatment from the impairment of a child's health and/or development. However, we stumbled across another factor, which in retrospect, should have been predicted. That was the 3rd tier of concern, namely parental attributes or risk factors. The category of ill treatment we likened to mediating mechanisms, and the impairment of the child's development, as evidence of harm to the child.

Parental Attributes

These results relate to the conference theme, because these three parental attributes were, respectively mental ill health of the parents, domestic violence, and alcohol and drug abuse. The three were roughly equally represented, but singly or in combination were found to pertain to 63% of families and 69% of children on the Register for Emotional Abuse. I will not talk here about domestic violence as there was no significant overlap between domestic violence and adult mental health. I do want to show a little of the breakdown, in relation to adult mental ill health and drug and alcohol abuse.

Adult mental ill health and/or alcohol and drug abuse applied to 46% of the families and 52% of the children. Adult mental ill health on its own was found in 31% of families and 38% of children. Alcohol and drug abuse on its own was found in 26% of families and 25% of children. The information on the adult mental ill health was taken from child protection conference minutes, and are therefore not formal adult diagnoses but they did include major psychoses, depression of various types, and parents who were hospitalised and parents who actually harmed themselves, or repeatedly threatened to do so. There was no specific mention of postnatal depression; there were two cases of learning disability which were not included under mental ill health. It is likely that the parents who repeatedly made threats of suicide suffer from a personality disorder.

Forms of Ill Treatment

I work with categories of emotional abuse and I try to fit the forms of ill treatment, the second tier, into these case categories. This is very much a retrospective sample, based on information from social workers and minutes taken from the families. The commonest forms of ill treatment which we see and which we have recognised in terms of the child are:

- inability to control the child appropriately and benignly
- inappropriate impositions on the children
- inappropriate exposure of the children to disturbing experiences.

37% had developmentally inappropriate expectations which included:

26% were denigrated or rejected.

20% experienced emotional neglect.
10% experienced repeated separations or moves.
5% where the child was used for emotional needs of the parent(s).
2% other.

Many children had more than one form of ill treatment:

Indicators of Impairment

Moving on to the indicators of impairment of the child's development, most of the children had more than one indicator and the order of frequency is listed below:

31% Emotional
20% School - significant developmental or educational underachievement.
22% Behavioural
12% Peer relationships
12% Physical
3% Other (sexualised behaviour)

What we term "emotional", includes anxieties, frank distress, and children who were either depressed, withdrawn or suffering from low self esteem. Behaviour difficulties ranged from oppositional behaviour to children who were extremely attention seeking. Difficulties in peer relationship included aggression as well as social isolation. Physical difficulties included small stature and complaints about symptoms which did have an organic basis.

Since the minutes were not written with the 3-tiered classification in mind, it was not appropriate to test for specific associations between parental risk factors, mechanisms of ill treatment and impairment of the child's health and development. However, we did find that in a family where there was, for instance adult mental illness, one child might be carrying inappropriate responsibility whereas another child might be emotionally neglected.

The last aspect of the research to which I want to refer, concerns the number of referrals to Mental Health services. We found that overall, 61% of the families and/or the children had been referred to Child Mental Health services. Interestingly, the rate of referral was modulated according to the availability of Child Mental Health services, so that in one Local Authority, where there was an extremely active and good Child Mental Health service, there was a very much higher rate of referrals than in another Local Authority where at that time Child Mental Health services were under-resourced. Some 43% of families had either already been known or were later referred to Adult Mental Health Services. I do not know the total number of children on Child Protection Registers, but if 25% are recognised as suffering from emotional abuse and 43% of those are referred to Adult Mental Health Services, this carries serious resource implications.

Conflicts of Interest

I approach the issue of conflicts of interest, as I spend my time talking to adults, by asking myself a particular question - "How can the child thrive or grow undisturbed?" If we think about children when dealing with adult mental health or alcohol and drug abuse, there are direct effects.

Direct effects include:

- physical danger
- fear
- sense of unpredictability
- discontinuity of care
- age-inappropriate impositions and expectations
- emotional neglect due to parental unavailability and unresponsiveness
- child drawn into parental delusions or psychopathology
- a sense of isolation/secrecy/shame

We have already heard about the physical danger.

Children's Needs.

I am labouring the point but I think we need to consider the children's needs in relation to the effects.

Children's Needs

- protection from violence
- protection from exposure to violence, frightening and disturbing adult behaviour
- continuity of care or knowledge of who will offer substitute care
- opportunity to ask for and receive age-appropriate explanations
- opportunity to express feelings about Adult Mental Ill Health
- freedom from age-inappropriate responsibility
- pursue own education, social and emotional development

Receiving age-appropriate explanations is extremely important. We found that for 92 of the 94 children we sampled, the emotionally abusing adult was also the primary carer. So in these circumstances, continuity of care has a meaning of its own and these children become extremely vulnerable. We had no cases where there were two parents and only one of them had an adult mental illness, alcohol or drug abuse problem. We thus assumed that where the other parent is not afflicted in some way, they seemed to be sufficiently protective of the child, for the circumstances not to require registration. We all know, however, that this is not always the case, and the needs of these children are enormous.

I want to talk about the **conflicts** arising because of these needs not being met. These conflicts take many forms and vary for different people in different situations. Conflicts exist first of all for the child, secondly for the parent, thirdly for the professionals, particularly those working with both the adult and the child, e.g. GP's, and lastly, the resource allocators. The conflicts relate to divided loyalties, to confidentiality (about which we have already heard), but if we choose to leave out the question of confidentiality and only talk about those cases where confidentiality is not an issue, we will still have a large number of children and parents to talk about. There is a conflict about the effect of the child protective actions on the mental health of the parent, and the belief that it can lead to the deterioration of the parent's well-being and, of course, there is always the conflict of allocation of resources.

In any situation of conflict it is important to choose the correct mediators. When adult mental ill health is known about, GPs are an important group of professionals who should know whether these adults have children and they should be able to connect the two. Even the absence of a formal adult psychiatric diagnosis should not stop us from thinking about the children.

Lastly we also need listen to what the children tell us. In a study from Denmark, in which children of alcoholic parents were asked what help they would like, they said that they would like to receive help from professionals who knew their parents, rather than from strangers. That would mean that they would not be regarded as clients in their own right, which they did not wish to be. Meetings of children in a similar predicament can also decrease their isolation and sense of shame.

10. Young Carers and Their Parents with Long Term Psychiatric Disorders.

Amanda Edwards opened the talk by stating that she worked on the Community and Adult Care Side, Social Services Inspectorate, Department of Health, whilst Peter Smith worked on the Child Care Side. Their jointly prepared presentation indicated the Department's efforts to work together on issues, particularly the impact on children who are caring within the context of how families manage illness and disability. They covered issues of definition and prevalence, and included some of the principles that had guided the policy of the Department of Health in this area.

Young Carers

The issue of young carers has emerged relatively recently, stimulated by a number of research reports and by media attention. Between 1994 and 1996, the Inspectorate ran a development programme which had two objectives:

- to raise awareness and provide advice on good practice.
- to review and analyse research and project work on young carers.

The work started in April 1995, with the bulk of the activity in two forms. One was a series of regional workshops and the other was some field work, which included visits to young carers and their families. These projects resulted in two publications, from which most of our presentation is taken. The first, called “Young Carers: Something to Think About”, which was about raising awareness and stimulating debate. The second, “Young Carers: Making a Start”, included some suggestions for practice and policy development.

We began this programme with the aim of challenging some of the attitudes and polarisation that was evident. There was an emerging orthodoxy which focused very much on children’s rights as carers and whilst this was very useful in identifying children’s needs within a family, it was felt by many, particularly by disabled parents, that this actually undermined their role as parents. Much of our work has sought to challenge such polarisation and promote a much more family based approach.

Definition and Prevalence

One definition of "young carer" that is sometimes used is “children whose lives or childhood are affected or restricted in some way by the caring process”. This definition seemed to be enormously broad and unhelpful. So the Chief Inspector in 1995 proposed the working definition, which we now use, - "a young carer means a child or a young person who is carrying out significant caring tasks and assuming a level of responsibility for another person which would usually be taken by an adult". The term refers to children or young people under 18 years, caring for adults (usually their parents) or occasionally siblings. It does not refer to parents under 18 who look after their own children, nor does it refer to those children who accept an age appropriate role in taking an increasing responsibility for household tasks in homes with disabled, sick and mentally ill parents. Some parts of our community, depending on their religious beliefs, on their culture or background and the gender of the child, will have a different concept of what is an age appropriate role for a young carer.

This definition was used by an Office of National Statistics population based survey, to determine how many young carers there are. Out of 12,000 households, 18 young people were identified that fitted the definition and interestingly, in only two of those households was mental health the primary difficulty with the parent. Of course dealing with small numbers makes extrapolation difficult. Studies of children who were known to young carers projects, have found that about one third of the children had parents with mental health difficulties and they were:

- | | |
|--|-----|
| • mental health problems - unspecified | 11% |
| • depression | 8% |
| • alcohol misuse | 5% |
| • schizophrenia | 2% |
| • agoraphobia | 2% |
| • autism | 1% |
| • drug misuse | 1% |

The Office of National Statistics survey estimated that there were a total of 32,000 young carers in Great Britain. *If we use the estimate that one third of the young carers have a mentally ill parent, then we are talking about probably 10,000 young carers in Great Britain having a mentally ill parent.* Some of these children will need little specialist attention, whilst others would need high levels of support to avoid possible present and future distress.

Effects of Caring on the Children

We hope, in this section, to enable the voices of the young carers to be heard by those of us that are involved in providing family services. Up to now we have tended to see young carers as a homogeneous group and have not divided them according to the nature of the disability or illness of the parent. Clearly this should be considered in future research.

In “Something to Think About” we summarised the findings of research which looked at the experience of young carers.

- Impaired educational development;
- Isolation from the peer group and the extended family;

- Lack of time for usual childhood activities;
- Conflict between the caring role and the child's own needs leading to feelings of guilt and resentment;
- Feeling that there is nobody there for them, that professionals are working with the adult;
- Lack of recognition, praise or respect for their contribution;
- Feeling stigmatised;
- Feeling that no one else understands their experience;
- Lost opportunities and limited horizons.

Research makes quite clear that many children feel loved and needed, have gained in maturity and self-esteem and have derived satisfaction from their caring role and from their responsibilities and influence within the family.

These are some of the main concerns that children and young people have raised with researchers:

- Someone to listen and understand. They very often felt quite resentful of professionals who did not recognise the degree of responsibility that they carried within that household, merely treating them as someone who opens the door and makes a cup of tea.
- Confusion of too many faces from one or many agencies that come to their house.
- Keeping school and friends separate from caring responsibilities. They have said how important it is to have an area of their lives, such as school and friends, kept separate and normal. Therefore there is some resistance to young carer projects in schools.
- There is a pervasive worry about disabled/ill parent/sibling and the future.
- Relentlessness of responsibility; time; tiredness; depression from responsibilities that they carry.
- Protection of disabled/ill parent/sibling from bullying/teasing.
- Working twice as hard to keep up at school.
- Lack of opportunities for normal activities/outings and they felt they had lost an important part of their childhood.

The wants and needs of young carers are often simple and straightforward. Four issues have surfaced. Firstly, the desire for information about the parent's illness and a likely prognosis. Secondly, some recognition by those charged with helping the family to accept the importance of their role. Thirdly, the importance of practical and domestic help. (When a nine year old girl was asked about her domestic scene and what might make it better, her wish was simply for help in the morning to get her little brother up and ready for school. So often simple practical and domestic help is all that some young carers are looking for). Finally, somebody to talk to and to express their concerns in an informal way that does not stigmatise the family. It doesn't mean therapy, or an appointment with a child psychiatrist, or necessarily more generic counselling.

Department of Health Approach

Firstly, the legislation. We think that our current legislation provides an adequate framework for the provision of assistance and services for young carers and their families. The legislation concerned is The Children Act 1989, the NHS and Community Care Act 1990 and the recent Carers (Recognition and Services) Act 1995, which included young carers. Some local authorities have not used their powers under this legislation, to provide a co-ordinated approach to young carers.

Secondly, it was important that staff felt able to recognise where children and families had needs and to refer appropriately for assistance. This means having the procedures and frameworks in place which brings the legislation together.

Thirdly, was the importance of securing a local multi-agency commitment to working on this issue, since it is quite obvious that many young people in this situation will come first to the attention of education, health, housing or social services. We heard a wide variety of views from young carers and their families about the type of assistance that was appropriate. Some people wished it to be based in school, some found special projects very helpful, whilst others needed the chance to be able to do things more as a family. It is important that people recognise this and have the ability to respond. "Making a Start" does include some suggestions both for education and for primary health care.

Fourthly we stressed the need for a whole family response. After some heated debates at our workshops, we concluded that children's rights and disability perspectives are not mutually exclusive. What we were seeking to promote was a balanced approach, which sought to:

- promote and enhance the parent’s capacity for independence and ability to parent.
- provide community (mental health) services so that children are not providing levels of care and taking responsibilities which are detrimental to their own development.
- consider whether the child has further needs which require the intervention of other universal or targeted services.

In “Something to Think About” we highlighted what actions are required by that sort of approach.

The first point we make is about assessment, and how important it is to start by recognising how the family were managing with the disability, and working on from there. The guidance on the Carers Recognition and Services Act included advice about how to carry out that sort of assessment.

The second point is that children and young people wish to be given choices about the extent of their caring role, and not supported simply to assume more tasks. As we have seen, children didn’t want to give up completely but would just like a little more assistance. A key point from the disabled parents perspective was whether, if they had more help, their children would love to do this .

The third point was the importance of taking time to get to know and assess a child’s needs which might well enhance the understanding of the needs of the ill or disabled parent as well as the separate needs of the child.

The fourth point was that local and health authorities should not direct resources away from parents to children which could have helped the parent to parent. This reflected another part of the debate about whether attention should focus on setting up specific projects to assist young carers or whether it should focus more on ensuring assessments pick up young carers needs and that suitable services are available.

Finally, a conclusion that is particularly relevant to this conference, was that through taking a sensitive approach to young carers, social workers should continue to challenge the public perception that social work intervention leads to children being taken away from their parents. In many, but not all of the research studies, this belief was the main reason given for not asking for help.

11. Developing A Parenting Approach

Before starting her talk, Christine Puckering, Consultant Clinical Psychologist at the University of Glasgow Department of Child and Adolescent Psychiatry, acknowledged a particular debt of gratitude to Tony Cox and also to Anne Jenkins Hansen, founder of the NEWPIN project. New techniques have now been developed, especially the use of video to allow parents to see for themselves what was happening in their interaction with their children. This has led to what has become known as the Mellow Parenting Project, which is currently the subject of a Department of Health evaluation. Ms. Puckering described this project and also showed a short video to illustrate more graphically, the results of this work. With the video, mothers could look back at what had been happening, moment by moment and take the opportunity to reflect on themselves and their parenting style. This can lead to substantial change.

The Research Project

Before the group starts, the mothers are interviewed and videoed at home with their child and there is a child assessment. The video is the property of the mother, not the property of the project. Parents choose when to use their own video in the groups. This opportunity to choose is very important and contributes much to their willingness to involve themselves in an intense one day a week course over 14 weeks. After the first week we get virtually no drop outs, so the family's commitment is considerable. Around 4 to 6 months after the end of the group programme, they are interviewed again about the changes that they have experienced, the help they’ve used and a second video is taken. Some 18 months after the beginning of the project, a year after they’ve finished the group, all the initial measures are repeated. To evaluate the project, results are compared with a control group not involved in this programme, who are using family centres instead.

A considerable proportion of the children in the group are on the Child Protection Register, but any child under 5 can attend where there is a breakdown in the relationship between the parents and the children. In addition, a combination of issues like domestic violence, parental mental ill health or consistent behaviour problems in the child, would be sufficient to enter the programme.

The Programme

The programme falls into a number of elements. The children spend part of each day in a creche and the remainder with their parents. In the morning the mothers have a personal group providing an opportunity to reflect on their own experiences. In the afternoon there is a parenting group, where the aim is to clarify how their childhood experiences facilitates or interferes with their performance as a parent. Ideally, to understand your child you need to put yourself in your child's shoes. If you have no recall of what that was like, or, if indeed, that was such a painful experience to recall, then seeing it through the child's eyes is very difficult to do. These are issues for the mother, and also for the father, since we have run groups for both. We have also run an abbreviated version with couples.

As well as its use in the group, the video provides a baseline measurement of anticipation, autonomy, co-operation and conflict, warmth and hostility, distress and containment and stimulation. From a research point of view these are coded as detailed, moment by moment interactive sequences, using a very detailed coding manual. In the group for the mothers who often have low levels of literacy, will describe a topic simply, such as "spotting trouble before trouble spots you", and not "anticipation". The mother might be asked to think of a time in the last week when things didn't turn out quite the way she wanted them to and to ask herself what she could have done beforehand that would have made it easier for herself and her child? A simple example of "anticipation" might be warning children 5 minutes before tea is ready, so that they have time to put away their toys and get ready, rather than simply putting the food on the table and then wondering why the children won't leave what they are doing. These issues would be shared in the group, with parents getting tremendous support from each other. We try not to play an expert role, but allow parents to talk about their problems and for the group to generate possible solutions for them to try.

We also have lunch together, staff, children and parents, including those parents who do not enjoy their children's company. So for half an hour shared activities are planned, which can be anything from finger games, bouncing children on your knee and singing songs, playing with Playdough and making iced biscuits, to arts and crafts. Even going to the supermarket is included, because that is an event that parents find very difficult, and we discuss beforehand what can we do to make it easier. Visiting the local library is also very important, for parents introduce their children, perhaps for the first time, to those very inviting rows of brightly coloured picture books. To mothers who say "I can't give my children books, they'll rip them up", we talk about what they can do to make this lovely resource available to the children. It is possible to take the book home, but keep it on top of the cupboard and only bring it down for a special time after lunch; so that the mother does not have to worry about it being destroyed.

The last element is homework, based upon issues that have come up in the parenting workshop. The mothers define what they want to work on, settling the children to sleep, hair washing, temper tantrums, or other issues. The following week we will review with mothers, the homework that they've done.

A Case Study

This case is about one mother who went through the group and is very happy to share this material. Linda, had two children and she was referred by the local child psychiatrist. Both children had been separately referred to our local child psychiatry service. The five year old had severe separation and sleeping problems. The two year old had extreme temper tantrums and was also eating poorly. Linda herself was extremely depressed. She'd had periods of depression in the past, the first one in her early twenties when her father, to whom she was close, had died. She then formed two rather hasty relationships, firstly with a man who became the father of her five year old child and secondly with a man who became the father of her two year old. Each relationship ended when it became violent. When she came into the group she was depressed, and had separated from her latest partner who was steadfastly waging a violent battle against her, even breaking into her flat at night. These frightening experiences had got to such a pitch that neither her daughter nor she could sleep at night, and she often spent the whole night with the light on, watching television. Naturally, next day when she came to the group she would be very tired and I sometimes felt that the most important thing we could do was give her an arm chair and let her try to have a snooze for an hour. She got tremendous support from the other mothers in the group and she began to take measures to improve the situation. She got in touch with Social Services who were able to provide her with an alarm button, and she eventually moved out of the area and formed a relationship with another man.

At the start of the programme her interaction with her son at meal times was very limited, and consisted of directions and instructions only. When he asked for more juice she said offhandedly, "Huh, get your juice later".

As the programme progressed, the interaction at meal times improved. Now they watched videos while he ate and they talked about the content of the video. However, the mother was now very controlling. Suddenly his eating was related to the video remote control: when he ate, it went on and when he stopped eating, it went off. She had taken control of the situation and she had taken control, not only of her son, but also of her own life. She eventually moved out of the area and started a new life, following a college course leading to a degree.

Near the end of the programme, the interaction had improved out of all recognition. When he was unhappy, the mother got down to his level and then she took care to find out what the child wanted: did he want a different plate, or did he want his toast turned over, what was the problem? The quality of her relationship with him had changed so that control was no longer an issue and the quality of the interaction was quite different.

Outcome

Both clinically and personally this project is paying off. From 21 families, of 12 children classified as at risk, 10 are now off the Child Protection Register, and although the other two remain on the Register, they are back living with their mothers. When asked what they would have done if they hadn't come to the group, some of the parents admitted that their child could have been a battered child or they themselves would have needed psychiatric help. I do think we are giving them the chance to enjoy their children and their children to enjoy their childhood. *Hopefully when these children have their children, the cycle of abuse and neglect will have been broken and we will not be needed.*

12. Legal Solutions - Confidentiality, Co-ordinating Assessment and Information Exchange.

Mr. Anthony Harbour, a solicitor specialising in health and social service law, prepared his talk on the basis of some self-posed questions: does confidentiality protect our clients or is it a construct behind which perpetrators shelter and against which service providers struggle? Does it impede in vital areas, the processes of child protection? He opened his talk with a brief look at the general principles of the law, before going on to a particular case example in which he urged us to look at the detail.

Legal Aspects.

A legal duty of confidentiality certainly exists and so it can be actionable. Cases in the healthcare confidentiality field are rare and there is little case law. The relationship between doctor and patient is one example of a relationship that creates the obligation of confidence. However, confidentiality is not absolute, and there are exceptions to the obligations of confidence, most obviously where a patient consents to a disclosure or where a court requires it. However, there are other specific exceptions or categories of exceptions and these include: statute, the notion of public interest and also the notion of "need to know".

Statutes

The requirement under public health legislation for doctors to notify cases of disease, is an obvious example. Another example would be the Police and Criminal Evidence Act, that allows the police to seek access to medical records for the purposes of a criminal investigation. There are other complications, like the Mental Health Act, etc.

Public Interest

In justifying disclosure without consent, the concept of public interest is talked about quite loosely. In one of few reported cases, the courts precisely defined the concept of public interest, giving as an example the investigation by the police of a grave or very serious crime. Similar advice is repeated by the General Medical Council. There is a sense that public interest, in the area of child protection, is being used to justify disclosure in a broader way perhaps than the courts have so far gone. An example of some current guidance on defining public interest, is given in Guidelines For Professional Practice, UK CC, 1996. I ought to say that the professional guidance in this field, whether from the GMC, UK CC, Law Society, whatever, it is very important because there is so little direction from the Courts or parliament. You'll see here that public interest means the interest means the interest of an individual or groups of individuals which, for example, would cover matters such as child abuse and here we are moving into an area where, if we are talking about justifying disclosure in the context of child protection, there is some guidance which gives some support to that.

Need to Know

This is a principle that was designed to ensure that a consenting patient received the best available medical care and a conventional analysis of any medical practice assumes that there will be shared information within a medical team. The difficulty with this construct is that it has been broadened beyond the medical although the Medical Defence Union's, "Guidance and Confidentiality", published earlier this year, refers only to health care workers in this context. To allow the NHS to function effectively and efficiently, personal patient information will be seen and discussed with other professionals and, indeed, administrative staff as well as the staff of other agencies contributing to a patient's care. But in relation to the care of psychiatric patients in the community, the breadth of this concept needs to be considered and perhaps be delineated, for example, do we include staff working in Housing Associations within the need to know net.?

Moving on to children, a further qualification to this idea of absolute confidentiality emerges, and this is the justification for disclosure in the best interests of the child. I am relying on the guidance contained in the publication: "The Protection and Use of Patient Information, Department of Health, 1996". *In child protection cases the overriding principle is to secure the best interests of the child, therefore if a health professional or other member of staff has knowledge of abuse or neglect, it would be necessary to share this with others on a strictly controlled basis so that decisions relating to the child's welfare can be taken in the light of all relevant information.* It is the **relevant** information that I want to discuss in more detail.

This guidance has no legal status, but in cases involving children similar guidance has been referred to with approval. For example, Working Together emphasises the positive duty on doctors to disclose information to a third party where child abuse is suspected, and this position has been adopted by the General Medical Council. It is important to stress that the courts have not adjudicated in this area. The Children Act does not create a statutory obligation to disclose without permission, although the courts in children's cases may be moving towards that position. Although Part III of The Children Act deals generally with the question of co-operation between statutory authorities, it does not create a legal obligation.

A Case Study.

As I said earlier, I think, the devil here is in the detail, so please bear with me.

This information is from a report produced earlier this year by Oxfordshire Health Authority. In January 1994 Darren Carr was discharged into the community, after receiving inpatient psychiatric treatment in a secure unit. In January 1995 an adult forensic social worker, attached to the secure unit, heard that Darren Carr was boarding locally in a household with young children, aged 6 and 4. This unit social worker, who was not a child care specialist, "remained troubled by questions of confidentiality" concerning the disclosing of information to others about his client, without his client's consent. So at the beginning of February 1995 the social worker spoke to his team leader, who gave him this advice. *"You have got no choice, if there is a danger to the children, that is the bottom line, let social services have that information and do what they will."*

The social worker then spoke to the duty officer at the children and families team and the conversation was recorded. During the conversation it was said of Darren Carr, who remember is boarding with two young children, "He has a personality disorder, his only offence is breach of the peace, attempting to kill his mother." The referrer feels there is a degree of danger from Darren Carr who has a violent background and is aggressive if provoked. The unit social worker then wrote to children and families as follows. "Darren Carr is known to our forensic psychiatric service, he is expected to baby-sit the two girls aged 4 and 6 whilst their mother, who is of similar age to himself works from 8:30 p.m. to 7:00 a.m. We have tried to evaluate possible risks to these children. Whereas Darren Carr has not got a history of danger towards children, he is known to act in an angry and impulsive manner towards adults and young adolescents. Darren Carr's troubled history includes parental separation, alcoholism and violence." Later on there is a reference to Darren Carr's earlier attempts to kill his mother. In conclusion, the unit social worker offered to attend a multi-agency meeting.

A process of consultation then took place between the child protection investigation team and the unit social worker. This process of consultation appeared to be designed to establish the following points: Firstly, Darren Carr was not a Schedule I offender, secondly, he had no dangerous history towards children and thirdly, the referral was not a full referral but was for information only. At the end of this process, in March 1995, the case was effectively closed by the secure unit. The local household where Darren Carr was residing had not been identified.

The original referral documents from the secure unit were filed in children and families miscellaneous files. In May 1995, the children were again brought to the attention of the child protection investigation team, this time from the older girl's teacher, who referred the case on the basis of concerns, including the fact that "Kylie had described how Darren Carr would hit her on the hand with a wooden spoon until she went to sleep". This referral was investigated, both children were seen, and a GP and Health Visitor were contacted. By the 9th June the file had been marked "No CP concerns. Transfer C and F team." *There had been no contact with the secure unit and the referral details provided by the unit social worker in February were not available to the investigator of child protection investigation team.* On the 26th June 1995, Darren Carr set fire to the house killing the two children and their mother.

The first thing that occurred to me, on analysis of this case, was that a clear appraisal of confidentiality issues did not in fact impede the transfer of information. Disclosure could have been justified on the basis of "public interest", "need to know", or the "best interests of the children". On the negative side, there was no properly focused risk assessment and there was an outstandingly poor understanding of the role of the adult psychiatric service. For example, the children and families social workers did not know what the adjective forensic meant or its implications. It is easy with hindsight, but having read the report again, there is a chilling inevitability about it all. I think what did happen here was that there was a transfer of confidential information to children and families, which then got stuck. Relevant information was not analysed and identified as being important.

I started off making an assumption that mistaken notions of confidentiality impede the processes of child protection. On reflection, the answer is much more complicated. Arguably, qualifying confidentiality to protect children has been embraced with some enthusiasm. The problem I believe, is much more in delineating what constitutes **relevant** information to be shared. There may be some cases where a scrupulous regard of adult confidentiality may be of some concern to the professionals treating the adult patients. However, the problem can be reduced by education and in particular, reassurance that child protection case conferences, within which disclosure takes place, operate a rigorous process of protecting confidentiality. I think what is much more problematic, is the breadth of information that may need to be disclosed, and the necessity for a proper appraisal of that information. If colleagues are expected to conduct proper risk assessments, then they must be given adequate information. Although there is a wide scope for disclosure in the case of children, disclosure must be tempered by the expectation that the disclosed information is relevant. This is the Department's guidance. What is relevant in the context of risk assessment? If Carr's case had been dealt with properly, **all** the information was relevant. This is where you may start feeling uncomfortable. So we need to discuss the limits of confidentiality, as well as the detail of information to be disclosed. This may be an area where there is potential conflict between those who care for adults and those who care for children and this, I believe, necessitates co-operation from both sides and further guidance

13. Managing Change

Robert Potter, Consultant in Child and Family Psychiatry, Bath Mental Health Care Trust, opened by saying that he and Maurice Lindsay, Group Manager, Children's Services, Bath & North East Somerset C.C., would be illustrating how they have responded to the needs of *families* by creating opportunities for change in systems of care delivery. Their response was not just for families where child protection issues are clear, but for families covering a whole spectrum of needs, including parents with mild mental health problems whose condition does not merit child protection considerations. He said that they would talk about the thinking that led them to what they were doing locally, but hoped it will be relevant to others elsewhere. Much of the preparatory work and many ideas were contributed by Jennie Bashforth who, unfortunately, was taken ill just before the conference.

Maurice Lindsay began the presentation by referring to a specific case and highlighting the lessons learnt from it.

Adult Mental Health Services and Child Care Services within the Directorate were involved with a lone parent with a history of depression. Community and hospital mental health services were provided to support the mother within the community and the children within the family home. Occasionally, respite foster care was provided for the children to give the mother planned breaks and also when she was admitted to hospital for treatment. Community based support enabled the family to reunite after such episodes.

During the course of 1996 circumstances deteriorated markedly. The parent's mental health problems became more acute: she spent longer periods in hospital including compulsory admissions. The Child Care agencies

became increasingly concerned about her ability to safely parent her children and care proceedings were initiated. In co-operation with the hospital based staff, including the Consultant Psychiatrist, the Child Care Social Worker advised the parent of these proceedings and the proposed plans for the future care of the children.

In parallel with this, the parent appealed against the decision to make her the subject of a Section 3 Order under the Mental Health Act. A report for The Mental Health Review Tribunal was compiled by an Adult Mental Health Social Worker. When compiling her report, this Social Worker clearly believed that child care arrangements would not change. Nobody mentioned the care proceedings to her. The hospital staff were firmly of the opinion that the parent's mental health difficulties were exacerbated by not being with her children. Indeed, the children were seen as a therapeutic tool to help the mother improve her mental health. The Child Care Social Worker sought to attend the Tribunal, but was advised by the Consultant Psychiatrist that this was not necessary as in his opinion the child care issues were separate to the parent's mental health situation.

Consequently, when the Tribunal took place:

- The mother stated that if her children had not been taken away, her mental health would be better and she could return home.
- The Mental Health Social Worker said that she could not comment about that or child care plans.
- The Consultant Psychiatrist made no reference to the discussion that he and the Child Care Social Worker had with the parent regarding care proceedings.

Not unexpectedly the Tribunal felt that it had insufficient information to make a decision, adjourned its hearing and requested the attendance of a Senior Manager to attend the next hearing to “**explain the rationale of the management of this case and to say what proposals there were for the future**” and the Director was subpoenaed to London.

It was evident that there had been a significant breakdown in communication between and within agencies, with one service seeing only the adult, the other seeing only the children. This was a major barrier to communication.

This was a complex case with dramatic, high profile effects. This case focused our attention on the lack of working together between the Child Care and Mental Health services, which went right through all our respective agencies and not just in extreme cases.

In looking at the way forward we found the Office of Public Management Briefing Paper “Joint Commissioning for Child Protection” to be particularly helpful - with its injunction to mental health practitioners to “See the Child” and to child care practitioners to “See the Adult”. This did not appear to be happening within our agencies. We discovered what we have termed “silo” thinking, in which Child Care staff see only the child, Adult Care staff see the only adult, never the twain shall meet. We firmly pointed our finger at the effects of specialisation, both within agencies and across agencies, for getting us into this position.

- The mystique that had developed around the two services
- Fear of making mistakes
- Perceived de-skilling - staff believing they do not have the skills to assess the adult and assess the children
- Avoiding such assessments and decisions because of the apparent de-skilling (it's your job to make decisions about risks to children/my job to make decisions about risks to adults)
- We had established blinkered services that focused on their own clients
- Segmented services that found it difficult to work together

The irony is that there are so many parallels between the services:

- both are high profile
- both are involved in significant risk management
- both have experience of the blame culture

At this stage we appeared to be facing an uphill struggle which required a firm response.

Bob Potter then proceeded to show how they took action, building upon the positive aspects of the situation.

Once, on a Trust management course, I was accused of separating my skills as a clinician from my tasks as a manager. That seemed to resonate with this idea of silo thinking. I didn't think I had the skills to think about issues from a managerial, or organisational point of view, although I did have skills as a clinician. But working with families and children I often ask about the positive, the strengths, and the successes and not just about the problems that they have. However, if I ask a family what has happened since I last saw them, they will tell me first of all about problems and things that have gone wrong. This doesn't mean that there aren't things that are going well.

In this particular case, there was much that was going well, up until the point that it went wrong. So we try to think about developing and building on the things we do right, rather than asking how can we stop ourselves doing things wrongly, leaving a vacuum.

An example where things have worked, relates to a lone parent mother in her late 20's, with four children. I had been asked by the Court to prepare a report. The mother hadn't been co-operative with the Court and had not turned up on more than one occasion. At times the children had to be accommodated because their mother felt unable to cope, and then she felt guilty and a worthless failure as a mother. Her supportive Child Care Social Worker felt that there might be more to this problem and she discussed with me the relevance of the maternal grandmother's history of bi-polar affective disorder. During my assessment of the mother and the children I felt that she was indeed developing a bi-polar mood disorder and not surprisingly, when she was depressed she was less able to care for her children. The oldest child, of nine years, then took on a caring role both for the mother and her siblings.

It was clear that this mother's own childhood experience had been identical, with her having to care on her own for her younger siblings. She was wanting to avoid facing what was happening to her and to avoid contact with mental health services. We worked out a care plan, involving the GP, Adult Mental Health Services and Child and Family Services. The Child Care Social Worker continued to support the mother in getting help for her own mental health problems, working across role boundaries, because it worked. Outside of my role, I could help the mother to make the transition into adult mental health services, since she felt that she could trust me because my report to the Court had addressed her needs and the needs of the children. The primary care team took a pivotal role in this co-ordination. This was a case that seemed to work well, due to people co-operating in crossing boundaries.

A second, more complicated case, involved two boys, one at junior school and one in secondary school. Both parents had long standing mental health problems including postnatal depression in the mother. One of the boys had significant emotional problems and was resident in a special school. Gradually we began to address the issues as a whole family, particularly what had it been like for these children to have a mentally ill mother - a suggestion which had come from the parents. In the first session, which was difficult for them, the mother came from the inpatient unit to our unit, for the work to be done with the family. This was possible because the nurse on that unit, the mother's own key worker, was able to prepare her for coming across and to help her deal with the issues afterwards.

These are examples of where it is working rather than where it is not and gradually we are developing other ideas. We have a good GP training scheme and many of the GPs specifically request child and family mental health experiences. This means that people who have trained locally go on to practise locally and that has a particular impact. We are now seeing at least one referral a week, from GP's and inpatient units, relating to a family with an adult mental health problem, with the question "What can you do to help us in working with them?"

These systems can only work when people are aware of the issues. Some of it is due to training, where some of the trainees have been acquainted with child psychiatry, and some of it is due to previous working together. We are also working on clear routes for consultation and referral.

We found that children visiting parents in hospital was an amazing trigger for referrals coming from the adult service. Seeing the child means they are much less likely to be ignored, since previously they never went near the admission wards. Child care social workers are beginning to help them keep in touch with their parents. Primary care is acting as the focus because we have the skills and the continuity. Our Chief Executive and our Operations Director have social work backgrounds in child protection and child care. So as an organisation we know what the "other side" is doing.

Maurice Lindsay continued, with the assertion that it can be different and asked "....how can *you* make it different?"

Experience had highlighted the importance of changing the way in which our services operate, if we were to build upon the good practice that had been evident in those cases. Discussions with senior management indicated that there was a climate and an impetus for change, since many people were dissatisfied with current systems. With a clear vision of how things could be and some practical ideas for the first steps, we felt we could move forward if we changed both the system and the culture.

*The theme underpinning our strategies for change has been **See the Adult and See the Child**. This needs to be the focus at every level within your organisation and between other organisations.*

In our opinion there are a number of key issues that must be addressed if you want effectively managed strategies for change and realise solutions, not least where do you start and how do you involve others?

1. What is the quality of your collaborative working?

Both Inter-agency and intra-agency.

2. Is there commitment at the top of your organisation and does this run through your organisation?

Is there similar commitment across and between agencies? **Who has an overview at Senior Management Level?** - within my Directorate the Head of Assessment and Commissioning Services (Assistant Director level) has responsibility for both Child Care and Adult Care services. The Group Managers immediately below that are specialists.

3. Does your organisational structure hinder or help you to achieve greater integration?

Do you have structural flaws that you may have to overcome?

Does the location of staff or the layout of offices help or hinder you?

Does your structure make it possible for strategies to be put into practice at the grass roots operational level.

4. How do you empower your staff (and services users)? Equally important how do you ensure that you do not disempower them?

You must consider:

How will you involve your staff in this change of culture?

How can grass roots practitioners get together?

5. How do your services integrate (given that they are very distinct specialisms)?

Do your child care and adult mental health teams talk to each other, work together?

What are your strategies for getting health and social services to work together to provide and develop services?

6. Do your Children's Services Plans and Community Care Plans exist as separate entities? Or do they come together and plan integrated services?

Do your Children's Services Plans offer provision for services to parents with mental health problems?

You must focus on what you do in your own agency but you must talk to other agencies and work together.

Our Authority established in January 1997 a multi-agency working party to plan the refocusing of children's services. At a conference in July, to launch the refocusing debate, workshops were held to consider the interface between child care and mental health services. The conference was attended by staff at all levels from all agencies and by members of the Social Services, Housing and Education Committees of the Local Authority. The widespread debate is now underway and it will be continued in a series of child care/mental health seminars planned for October and November.

We have established a multi-agency childcare/mental health forum with the task of drafting policies and procedures to co-ordinate child care and mental health services. Also we have made arrangements for adult mental health service social workers to work with our child care duty officers in the Referral and Assessment Teams. Each social worker will experience the establishment of close links and the undertaking of joint visits and assessments. Similarly, child care social workers will be working with the mental health duty team and the approved social worker service.

This experience will be included in induction programmes for all new staff and built into a performance appraisal and personal development plans for all existing staff. We have also established identified consultants within each child care and mental health team for members of each service to draw upon.

We are setting up systems to encourage joint pieces of work - for the assessment of the need for services and the delivery of those services. Mental health staff are included in the core group of workers for child protection cases; Child care staff are involved in care planning/discharge meetings for parents. Joint training is under way within the multi-agency child protection training programme and the overall training programme for the authority.

As a newly combined Directorate, we have integrated the provision of child care, adult mental health and housing services to children and parents. Joint training is underway. *We provide support to avoid the loss of tenancies by adults with mental health difficulties. We have no parents with children in Bed and Breakfast or Hostel accommodation.*

We are also looking to provide services in conjunction with the voluntary sector.

What to Avoid

- Avoid over-focusing on your own agency.
- Avoid merely creating different silos.
- Avoid starting the debate but not doing anything about it: nothing is more de-motivating.
- On the other hand, don't become complacent. Don't just get change going, keep it going, plan for how you will sustain things.

Finally consider what militates against collaborative working. A useful way of doing this is to ask your staff to brainstorm "How can we make it worse". List the suggestions, stop doing these and thereby effect immediate improvements.

Some of the ideas that I became aware of through this process can certainly help you to screw up collaborative working:

- do everything by phone.
- don't confirm anything in writing.
- believe in intuition.
- presume everybody else knows what you are doing.
- assume everybody is doing what they should be doing.

Conclusion

In our local experience, what appeared to be negatives have in fact led us along the road to solutions. By employing the strategies and implementing the practical actions outlined in this presentation, we have begun to establish greater confidence in collaborative working between Child Care and Adult Mental Health services.

See the Adult and See the Child is not merely a theme. It will determine our thinking, planning and service delivery. We hope that our local experience will be of use to others.

14. Solutions on the Ground: A Family Mental Health Service?

Adrian Falkov, Consultant Child Psychiatrist, Department of Child and Family Psychiatry, began by making the point that his joint presentation with Dr. Nadia Davies, Consultant Adult Psychiatrist, Lambeth Healthcare (NHS) Trust, brought together a child and adult psychiatrist on the same platform. This was an important indicator of possibilities on the way forward, and an optimistic response to dilemmas and conflict - both real and apparent, between representatives of services for children and parents. He and Nadia had met 18 months previously and their respective interests in service development for mentally ill parents and research into children of parents with schizophrenia provided an opportunity for a dialogue to begin around many of the issues which have been highlighted at this conference. Their collaboration in seeing families together, ultimately led to her recent appointment as consultant adult psychiatrist in the same Health Trust, with a remit to participate in the development of **a joint service for mentally ill parents and their children.**

Adrian Falkov continued, that despite their optimism about opportunities for working together, they were keen to ensure a note of caution and realism. For despite having achieved the structural change required for a joint service,

they were merely at the beginning of trying to implement necessary changes in procedures, policies and practice. He and Nadia would therefore be emphasising **efforts**, rather than solutions. Following a brief historical note by Adrian, Nadia discussed relationships between child and adult psychiatry and Adrian then presented selected findings from an inter-agency survey, a description of *FAMILI* - the 'Families and Mental Illness Initiative' in West Lambeth and some examples of conversations with children and parents to highlight current practice.

Historical Background

As recently as the 1950's, the attitudes of institutional psychiatrists in America could be measured by their reply to an important question: " How does the psychiatrist see himself in relationship to patients' families? ". The interviewers noted that: "Doctors sometimes stated directly and more often implied that since certain factors in the husband-wife relationship contributed to the husband's illness, it was the duty of the psychiatrist **to stand between** his patient and the wife in order to protect the patient. They defined the limits of their responsibility by indicating that the patient is their problem, and that **the wife should seek help elsewhere**". Little wonder then that it was difficult to keep children in mind.

Since the mid nineteen-fifties, the introduction of medication, together with ongoing social changes have led to a dramatic reduction of institution based psychiatric care, most recently Care In the Community. One of the unplanned benefits of this policy has been to make children whose parents are mentally ill, more visible. However, their plight is not a new issue and yet there continues to be a lag between research and clinical practice and an ongoing shortfall in service provision. So why has it **always** been so difficult to keep these children in mind? Will the current mood of optimism lead to observable changes and measurable benefits for children and their ill parents?

Nadia Davies, who had taken up her new post as adult community psychiatrist three days earlier, then stated that she intended to explore some aspects of the relationship between adult and child psychiatrists and hoped to convey her own optimism for joint working.

The Relationship between Child and Adult Psychiatry - a shared vision?

Apart from the significant changes in psychiatry over the last 30 years, which Adrian mentioned, the emphasis on rehabilitation has made us all focus more upon the patient's overall quality of life rather than the patient's symptoms alone. This has inevitably led us to consider joint interagency working along multidisciplinary lines. Recent legislation, such as the Care Programme Approach, also points us in this direction. The increased emphasis on addressing all the needs of our patients, who are also identified as parents, has forced us to consider the relevance of child mental health and social care services.

Why, some may wonder, has it taken us so long to propose joint working? There are many theoretical, practical and organisational reasons, some of which I will outline below.

Paternalism (Adult Psychiatry) vs. Parentalism (Child Psychiatry)

In the past adult psychiatry took a paternalistic view of psychiatric illness. The patient was seen as someone who was basically incapable of functioning in society and this fuelled the building of the Victorian asylums. Social change in the '50s and '60s with the emphasis on self-expression, psychodynamic processes and the rejection of the medical model did, I believe, damage the relationship between adult and child mental health services.

This has slowly changed. Fewer than a third of patients have a chronic unremitting decline in their course, whilst the vast majority have a relapsing and remitting illness and need varying levels of treatment and support. Adult mental health workers now see themselves as advocates for their patients, protecting them from stresses which may precipitate relapses and from assumptions about their lack of competence. However, a fear still persists that nobody with a mental health problem can be considered an adequate parent.

Biological vs. Psychological Models - are we still polarised?

In the words of an eminent biological psychiatrist *'to have forgotten that schizophrenia is a brain disease will go down as one of the great aberrations of 20th century medicine..... in the darkest days psychiatrists were regularly accusing parents of schizophrenics of inducing illness in their children (Murray 1994)'*. As a backlash to this adult psychiatrists became suspicious of any psychological explanations or interventions and particularly any focus on the family.

Fortunately over the past 20 years much research has challenged this dichotomy. In adult psychiatry advances in our understanding of the structure and function of the brain have not yet been sufficient to adequately explain the causes of psychiatric illness. At the same time advances in psychological treatments and the use of Cognitive Behavioural Therapies, such as the work of Julian Leff, with expressed emotion in families, has caused a resurgence of interest in psychosocial aspects of treatment for adults

Through the same period child psychiatry appears to have moved away from the dogmatism of psychological theories of aetiology. The child is now seen as an interactive agent with pre-existing biologically determined characteristics that influence and are influenced by the environment.

The Community Mental Health Team. (CMHT)

Over the past 18 months Adrian and I have jointly assessed families of psychotic patients who were known to the CMHT that I was working with in East Lambeth. In that team a keyworker would identify the needs of the patient on her/his caseload - psychological, social or medical, thereby also acquiring an **awareness of the existence of children**. We therefore had a system in place which allowed us to identify all patients who had dependent children. We invited child psychiatric CPNs into the CMHT, in order to deal with those cases where children were having difficulties and also for the CPNs to educate other members of the CMHT. Now that we are working in the same Health Trust the scene seems to be set for harmonious joint working. During this time discussions within our team and between adult and child professionals have highlighted a number of recurring themes which can act as barriers to integration between workers and impede the development of a joint service.

Anxiety. Key workers from the Adult Mental Health Services are anxious about the level of risk to children of their patients, which they do not feel equipped to assess. Once the need is identified they feel responsible for those children. We are hoping that this anxiety will be reduced through joint assessments utilising the skills of both adult and child mental health practitioners.

Envy. This can be due, I think, to the misconception that child psychiatrists have more resources and more time than adult psychiatrists to complete their assessments. Again, we hope that this will decrease when members of each team work together.

Some of the CPNs have said 'We do it anyway'. Members of teams become concerned about other specialists coming in and completing part of the assessments that they were handling before. Written responses from community mental health workers suggest that the CPNs in the Adult Mental Health Teams are aware of children's problems, but they are not reacting to that knowledge.

Thresholds. This is a problem that I think will be particularly difficult to overcome. The time pressure on children's developmental needs is of a very different order from that of psychotic adults who are undergoing a steady rehabilitation programme. These fundamental differences can lead to disillusionment. For example, it is very disappointing to refer patients with their children, who have educational or behavioural problems, and to be told that the problem has "gone too far" and there is nothing more that can be done, or that a referral should be made to social services. Similarly with parents who are referred to adult services it must be frustrating to be told that you may have to wait for 18 months for any change to take effect, or that 'there is no treatable psychiatric disorder' or that the problem should be dealt with by the GP or Primary Health Care Team.

Parenting is not an adult mental health issue This idea, held by some members of CMHTs, indicates an excessively rigid adherence to the medical model. If our aim is to maximise our patients functioning, then for parents with mental health problems this must include improving their parenting skills, which is a life skill akin to employment skills. If occupational therapy and employment training are accepted as useful treatments, it seems absurd that parenting skills training should not be.

Over the last 18 months I have become aware of just how much my patients worry about their children and their interaction with their children. These parents are concerned about the effect that their illness may have upon their children. They find this extremely difficult to discuss either with their children, with their children's teachers or with the mental health professionals involved in their care. With these issues in mind I want to present a clinical case which I think illustrates the different perspectives that professionals from different disciplines can have.

A Case Study

Mr C. is a 35 year old married man with two children aged 5 and 7. Eighteen months ago he was admitted with a first episode paranoid psychosis, after presenting with a 4 month history of auditory hallucinations. He felt stigmatised about hospitalisation and refused family visits.

Three months after discharge, his GP requested an assessment of the children who were exhibiting behaviour problems at school. The first family meeting was extremely tense and communication was difficult. The children were unable to settle or participate actively in discussions. Father was mostly silent but intermittently critical of the children's behaviour. On one occasion he seized one of the children by the arm to prevent her from biting her nails. Father's admission to hospital had not been talked about in the family. Both parents seemed keen for talking to occur with the children but were unable to agree on how this should happen. The children provided fragmented responses about their worries when Father suddenly 'disappeared' and whether they would ever see him again. They also mentioned their Father's headache which made him 'shout at us'.

Adrian was keen for this more open dialogue to continue but I was anxious that the fragile state of my patient might be affected adversely. We suggested that the children might have more questions and that the parents might spend some time agreeing a strategy on how to support them in this for our next meeting.

In fact a number of informal discussions within the family occurred at home following this meeting and the children settled.

Unfortunately, a few months later Mr. C's mental state deteriorated and his wife asked me to arrange another family meeting. At this assessment we agreed to see parents and children separately because of the anxiety about Mr. C's mental state. Father was again suicidal, paranoid and spending long periods alone in bed. We linked up to discuss our findings and I was surprised to find that the children were feeling 'fine'. They had indicated that they felt much better because 'daddy is quiet and he isn't shouting at us'.

I have tried to convey my optimism in relation to existing joint working and the prospects for establishing a joint service. There is a momentum of change in adult psychiatry which doesn't seem to be slowing down and people feel optimistic about the changes that have taken place. I know that is not what some people have been describing to me, but certainly this is my recent personal experience.

Adrian Falkov, resuming the presentation, next described *FAMILI* - the **Families and Mental Illness Initiative**, which had been developing over the past 18 months, during the time he and Nadia Davies had been working together. This initiative, he continued, was a three year Joint Finance collaboration between Lambeth Healthcare and Lambeth Social Services, to specifically target mentally ill parents and their children. It comprises a community psychiatric nurse, Marilyn Murphy, a social worker, Ulrike Antweiler, and a part time administrator, Geraldine Xiberras, based within the Child Psychiatry Department. He gave a special mention to Peter Loader, Child Psychiatrist and Clinical Director, the initiator and supporter of the venture, Tom Craig, Professor of Community Psychiatry, whose vision was essential and the guidance and encouragement of Danya Glaser, Bob Jezzard and Antony Cox.

An Interagency Survey

Our first objective as part of the 'Families and Mental Illness Initiative' was to ascertain from professionals, using a self report questionnaire, firstly how many families in contact with local mental health and social care agencies had both a mentally ill parent and dependent children. Besides raising awareness this was an attempt to gauge the number of families who might be eligible for the service being proposed. Secondly we wanted to explore professional's beliefs regarding the impact of parental mental illness on children. 8 sites were involved - 6 adult mental health settings, an adult social services resource centre and a Children's Social Services Area Office, all serving a similar geographic area.

From a total of nearly 1600 individuals known to the participating teams on each of the 8 sites, there was a return rate of 63%. There were 185 positive returns (18%) which met the inclusion criteria, indicating that *nearly one fifth of individuals known to a Mental Health or Social Care Agency in a defined area of a deprived Inner London Borough has a severe mental illness and dependent children*. Parents with severe and enduring psychiatric disorders were in contact with **all** components of the mental health service. Furthermore, at all sites, the quality of information provided about children was poor. Such basic information as numbers of children, their age and

gender was missing in at least one third of returns. In 36% (65 families) no information was provided about who looks after the children.

Nearly 2/3 of ill parents were women, 37% of whom were recorded as having a current diagnosis of psychosis. In a quarter there was a history of known self harm and in 31% there was a history of compulsory admission requiring use of the Mental Health Act.

These findings help to justify the relevance of this conference and the efforts being made to address some of these issues.

A Family Mental Health Service?

To date we have had nearly 200 referrals and many of these from adult services have been complex and multiple-disadvantaged families in which there were concerns about a child's safety which were not straightforward. Child maltreatment is not an inevitable accompaniment to parental mental illness, but this is often a feature of the early stage of our relationship with adult referrers. As a consequence we have at times had to encourage involvement of Child Protection Services rather than therapeutic provision, and limit support for parents to ensure that children remain safe.

Our objective, through closer working with other services, is to become more pro-active and encourage earlier discussion and referral, so that we can begin to tap the less visible majority of parents and children whose needs, whilst diverse, may be more amenable to successful intervention and more rewarding for collaborative efforts. A balance is thus required between the complex cases where poor prognostic features predominate and less extreme situations where opportunities exist for treating parental psychiatric disorder, improving parent-child relationships and preventing abuse.

Besides the ongoing referrals, regular consultation and teaching now happens in a number of mental health settings and we are also doing an increasing amount of joint clinical work, especially with adult CPNS.

Whilst establishing links with mental health services has been a primary objective, we recognise that mental health issues present numerous opportunities in different settings. We are establishing a therapeutic parenting programme at one of the CMHCs, and we have completed a small pilot project with the Brixton Family Welfare Association to support isolated mothers with chronic depression who are not known to mental health services. There is also a pilot Health Visitor Training project being planned which will establish links with that service and provide access to both the child and adult mental health units.

Talking with children and parents

We are currently working on approaches aimed at improving communication about parental illness within families, with particular emphasis on exploring children's understanding. The 1955 Journal of Social Issues provides some material. In the section on 'communication with children', a parental perspective is conveyed. The authors state: "In interpreting the father's illness to younger children, almost all the mothers attempt to follow a course of concealment. The child is told either that his father is in a hospital (without further explanation) or that he is in the hospital suffering from a physical ailment (a toothache, a tummy ache, or a headache). while the mothers protest that theirs have been sufficient explanations, there is both insensitivity and uncertainty in their responses."

Well, we know even young children do understand, but they need to be talked **with** if we are to know what they think and what sense they have made of their experiences. This talking requires time and effort to engage, it requires opportunity to work flexibly, in different settings and with sufficient scope for contact according to the child's needs. Here are 2 descriptions.

Sarah, an 11 year old girl provided a description of past problems when her mother was acutely psychotic: "..she was sick - when I was younger, mum had a problem. She had difficulty with us 4 kids - sorting us out for school - she wasn't getting a lot of help and she was shouting a lot. Her words were all jumbled up - didn't come out properly. She was always asking me for cups of tea so I was late for school. I told the teachers an excuse that mum overslept and I had to make breakfast for the younger ones - mum didn't want them to know she was sick because she thought they were watching her and coming round ". She went on to state that she thought it very unlikely

anyone was watching because "if there were watchers I'd have seen them - but I didn't tell mum this because she would have said - how do you know?".

Tom, an 8 year old thought that the cause of his mother's illness was confusing: "Its not like a tummy ache or a cold - but she's not feeling well. She thinks she's the king, then I know something's wrong ... in the neck - where she speaks, or maybe the heart - it's a very important part of the body- makes you do things, or maybe the mind - not the brain because the brain is just to make you think and **the illness is the things she says ...**".

Through talking with parents about their children we have found that, rather than jeopardizing therapeutic relationships, more open discussion has served to provide them with an opportunity to ask for help, to express fears and obtain advice. These conversations have revealed a wide spectrum from impressive coping despite significant adversity through to vulnerability, risk and serious child protection concerns. A lone mother, socially isolated and depressed who was wanting to run away said: "I only enjoy the company of my children when I feel happy myself - I can't remember when I last felt happy".

Conclusions

Care in the Community means that ill parents and their children will be spending more time together.

The survey showed that parents with severe mental illness are known to both adult **and** child agencies. The extensive lack of awareness about even basic information concerning children amongst **all** services helps to justify the increasing emphasis being placed on improving joint working.

A **broader approach** to assessment and a conceptualization of services which incorporates the health *and* social care needs of children *and* parents is required. To support these changes, a systematic and accessible mechanism for recording which adults known to services have dependent children and which parents have severe mental health problems, is required. Initiating **earlier communication** between different agencies could reduce the need for traumatic separations and enhance quality of life for all family members.

Training to improve practitioners' recognition of and responses to the needs of children and parents is necessary. For adult mental health teams this requires consideration of the interpersonal context of their patients, in particular their role as parents, their childcare responsibilities and the nature of their children's experiences within the parent-child relationship. For practitioners in children's services, achieving a mental health perspective is essential, including greater awareness of the impact of parental psychiatric disorder on child development and on childcare practice decision making.

There is a complex interplay between mental illness and loss, both physical and emotional. Losses range from short term, crisis related losses to permanent changes in family composition and children's carers as a direct or indirect consequence of mental illness. Failed hopes, aspirations and expectations involving both parents and children have life changing and lifelong implications within and between generations, highlighting the need to address these consequences in a variety of practical and therapeutic ways. Mental illness must be seen as but one of a number of factors and processes which operate in a complex web of influences to adversely affect the quality of life for so many families. Finally, whilst all children do not require referral for treatment, parents have a right to expect that, despite being mentally ill, their childcare burden will be recognized and to know that their children will be given the best possible chance for optimal development and fulfillment of their hopes and dreams. I will end with an extract from a conversation I had with a mother who has a chronic psychotic illness which predated the birth of her 12 year old daughter, Sally. When considering the future she stated: "I don't think I'm strong enough - If I'd known (about the illness) I wouldn't have had her - It was selfish - because I thought I might be lonely. She's always saying she loves me, but I know I've failed her." She goes on to describe how "because Sally is bright, she dominates me - my brain is dead - it's not like it used to be - so I ask her to change the Hoover bag, the tele-text. If we get a new phone - she does it - you know Doctor - she's like the man about the house, so that person's going to take control - they're the superior brain, but then I resent it because I'm the elder - I hope she finds a good man and a happy life - that this business with me won't affect her future".

15. The Michael Sieff Address

In opening his talk, Mr. Boateng MP, Parliamentary Under Secretary of State at the Department of Health, said how delighted he was to be giving the 12th Michael Sieff Address, both as regards the continued importance of the Foundation to the Department and to the work the Foundation has carried out for the welfare of children over the last 11 years. He continued by stating that the full Conference deliberations will be conveyed back to the

Department of Health by those officials at the conference, to feed into the work the Department is seeking to develop in this area.

Department of Health Strategy

Since this is the first time a Labour Minister has had the opportunity to address the Sieff Conference, Mr. Boateng felt it would be useful if he drew attention to the current themes of the Department of Health and their context in relation to the broader vision the new Government has for society as a whole. The Prime Minister's themes are centred upon creating sustainable, safe and sustaining communities that form a cohesive society, bound up by their rights and responsibilities, which is the bedrock of any successful society.

We must ensure that the role of families and parents in society, the building blocks of stable communities, and vital to the upbringing of children, are given a new emphasis.

Both parents and children have rights and responsibilities and the Government has to strike the balance between them. The role of the State is to provide the context within which parents and children can thrive in safe communities and achieve their full potential. Maximising everyone's potential, especially the vulnerable, is one of the major themes of this new Government, challenging the culture of dependency in terms of policy and administration strategy.

Carers

The death 11 years ago of Jasmine Beckford was the force behind the 1st Sieff Conference. However, there are many other children who suffer abuse which is not "headline" material and have unmet needs, where lives have been ruined and potential stifled. Although much has changed for the better since then, we must continue to improve our responses to those at greater risk. We must not forget those children and young people who suffer from denigration, humiliation and neglect or carry burdens of caring for parents with disabilities, with insufficient help from services. Many children from different sections of the community find themselves in the position of being carers and they vary in resilience and vulnerability in their ability to cope. Children as young as 8 or 9 come to my surgery and bring their parents along. Some simply need someone to talk to and get help in understanding. They need the opportunity to take breaks from caring that will help prevent their social life and education at school from being disrupted. If they are denied this help then resentment and bitterness can emerge in adolescence. *A lost childhood cannot be regained, though for many young people whose childhood seems to shrink and shrink, this would seem to be a very real task for us all.* Carers play a vital role in society, be they parents, young people, uncles or aunts, and we must ensure that their views, concerns and needs are central to our deliberations and the development of policy.

It is accepted that children and young people cared for by parents with a mental illness are at greater risk of developing mental illness problems of their own. This mental illness may reduce the capacity to be a good parent and can create a life of uncertainty and tension for children, adversely affecting their future. *Child mental health will have a higher profile with the Government in the future than it has had in the past.*

Social Inequality and Exclusion

Inequalities in society will be one of the Government's main concerns, as the Green Paper on Health will stress later this autumn. Mental illness, substance abuse and learning disabilities all place people at a disadvantage and stigmatisation leads to social exclusion. The additional pressures of poverty, inadequate housing, racism, domestic violence, unemployment and educational failure, further enhances the risk for all family members. Ethnic minorities, some 6% of the population, are all too familiar with these aspects of deprivation. It is essential that all groups in society have equal access to services.

Services will have to pay particular attention to those at greatest risk, especially those who feel alienated and excluded, since this exclusion is a major drain on the resources of this country, on its morale and the quality of life of its citizens. The Government is committed to an inclusive society in which all participants have a stake. This presents us with some real challenges, which the Prime Minister will address himself, through a special unit at No. 10 ensuring that, in a focused way, the vulnerable and the young do not lose the benefits of the regeneration and the refurbishment of our society.

Health Action Zones

Central Government cannot do everything. There are those things that the State does collectively well and there are other things that are best done by empowered individuals, correctly enabled. When that empowerment is undermined, the individual is weakened, perpetuating dependency and triggering a vicious cycle of decline in their morale and in their own capacities. We aim to develop a challenging, sustainable environment in which those who are able, can participate and those who find themselves disabled are stimulated to maximise their contribution to the community.

One of the ways we will proceed is the establishment of Health Action Zones to set the agenda and priorities for community and local action, by bringing together relevant agencies in a spirit of co-operation and partnership. We have to make sure that mental health is now regarded as central to their tasks.

Agency Co-operation

The Prime Minister has stressed that education will be a major aspect on which this Government will be judged and the use of school league tables will be one measure of this success. However, we have to ensure that those vulnerable people with learning difficulties and mental health problems, who would never normally feature in league tables, are included, by more effectively measuring added value. Effective early intervention can add enormous value to the lives of vulnerable young people and children and the Government will be giving a new priority to research and development in this field. If this work can establish the real value of early intervention by evaluating outcomes, then it will be easier to win resources to build it up. This an important way of justifying resource spending, when resources are stretched and it is vital that those working in this field, both statutory and voluntary, take on board this message in their search for extra funding.

In stressing the need for co-operation and partnership, we in Government also have to make sure that we have in place the statutory and institutional arrangements which facilitate rather than hinder such practices. In the medium term, we will be addressing the vital interface between local authorities and the NHS. In the interim Estelle Morris and I have begun the process, looking at the Children Act and at policies for Early Years Learning, to see where there may need to be a reconfiguration of policies between the Department of Health and the Department for Education and Employment. Thus, on the ground, it can be possible for Education, Social Services and Health to work more effectively together.

It seems to me that the work of the Michael Sieff Foundation, with its core objective of co-operation and partnership, is of particular importance in this regard and is reflected in the disciplines and backgrounds of the delegates at this conference.

We must not delude ourselves about the difficulties to be overcome, since not all agencies share the same priorities and not all policies have been compatible at Government level. There are also many legitimate differences in philosophy and approach to tackling the many problems that exist within our society. The first steps have been taken in the new relationships that exist between the Department of Health and the Department for Education and Employment, where the work of Government will be considered as to its impact on children. The same applies to Government in Wales and Scotland. We do not intend to allow boundaries and territorial disputes to prevent effective work being focused on the needs of children, either at Ministerial or grass roots level. This will require all of us to think creatively, to collaborate, and work with our minds open to new ideas and new people. Government has a duty to encourage this and the new round of Section 64 criteria bids should have the mental health of children and adolescents as key areas.

Over the last few years Working Together has done much to promote better joint working co-operation between agencies. But we all know it needs revising and updating to ensure that child protection is placed firmly in the wider context of services for children in need and their families, and this would be a key to enabling the right support and services to be delivered. Of course this revision will retain the best elements of existing systems and we would welcome your views and contributions as to how to strengthen and tackle these complex revision issues. No one group, committee or authority or even parents and family alone can do this. We have to engender and harness that recently manifest caring impulse in the community as a whole. We all have to ask ourselves what we can really do to provide those channels for caring and concern.

Early Intervention

Not all mental illness can be avoided, but its impact on others can and should be moderated. Early recognition that a parent may inadvertently be placing a child at risk is more likely to lead to a resolution in partnership with that parent. All too often the understandable reaction is "... we can't take the risk, we want to get the child out of there." Of course we must be aware of the risks, especially with vulnerable children, but you can reduce the risks by effective early intervention, which with openness and honesty makes the parent part of the solution. Early intervention should be about sensitive enquiry to uncover doubts and fears, asking simple questions that help identify people's difficulties and working together to find solutions. We as a Department have commissioned an overview of the effectiveness of early intervention and a conference is being planned for the spring of 1998, to enable us together to reflect on its outcomes.

Good Parenting

In conclusion I would like to talk about good parenting and society's role in promoting it. Many parents do not have the skills required to meet all the needs of their children. Much is now known about the impact on development of over harsh or inconsistent discipline, of neglect or lack of care and equally of over protection and inappropriate indulgence. Training is accepted as an important part of our everyday lives and it should not be regarded as an admission of failure by anyone to recognise their needs for training in skills of parenting, in the context of family support, in the context of marriage support, or simply in order to maintain and develop a variety of relationships. We in the Department intend to place a much greater emphasis on parenting in the period ahead and encourage innovative and new thinking in this area. It needs a balanced perspective, that is not paternalistic, patronising or condescending, nor should it be prescriptive in a doctrinaire sense. On the one hand it should recognise where simple means of practical support and information may suffice, but on the other it should recognise when children and young people who are at more severe risk, need protection.

Conclusion

I have presented some insight into the vision and tasks that the new Government has set itself in the period ahead. These are exciting times, but equally disturbing and challenging times, when so much of what we hold dear appears to be under pressure. There is a great opportunity for all of us working together in co-operation and partnership to make a difference by developing a strategy for change and improvement. It is not going to be easy, but I am heartened by what I know to be deep reservoirs of caring among the real fund of talent and expertise that exists in this area. Much of it is here tonight and for that we owe a debt of thanks to Michael Sieff and those who have followed in his footsteps.

There followed a **Discussion Session**, from which the main topics are summarised:

- **Mothers Back to Work.**

Wendy Stainton Rogers sought the assurance of the Department of Health, that as Harriet Harman expands child care opportunities, allowing women to move out of dependency and into work, that child care in this context will place the needs of children first and not the needs either of the Government or the parent.

Paul Boateng: I am absolutely clear that this will be so and I am in no doubt that Harriet Harman agrees. It would be false economy and contrary to all I have said tonight, to meet the needs for women to be free in the market place at the expense of the welfare and educational development of young children. Gordon Brown has already made new money available for the high quality skills training of young people in the delivery of health care. Thus we will enhance the life experience of the carer, the child being cared for and for the mother free to work.

- **Minister for Children**

Michelle Elliott, Elizabeth Haslam and Eileen Vizard all raised the issue regarding a Minister with overall responsibility for children across all Government Departments. **Naomi Eisenstadt** also stressed the need for the Department for Education and Employment and the Home Office to develop the same child centred approach that is evident with the Department of Health.

Paul Boateng: The Government have decided that a Minister for Children will never be appointed since it is not the most effective or efficient way to move children's issues forward. In England, the Home Office has specific

responsibilities for children's justice issues, the Department for Education and Employment has responsibility for children's education and the DSS has responsibility for children concerning child benefits. There are people in each Department who have been given a designated responsibility by the Prime Minister to take their children's issues forward. They are in the best position to influence and co-ordinate the work of civil servants within their Departments and also to influence events on inter-Ministerial working parties. They are answerable to the Prime Minister for their performance. A Minister for Children would never be able to function in this way. I urge you not to proceed along that line but concentrate on the points made about ensuring that there is a child centred approach across all the relevant Government Departments. The Government is now addressing Early Years Learning and Juvenile Justice. We want you to play a role in these issues and it is the Government's responsibility to make sure that you have the opportunity to input your views and ideas.

Eileen Vizard and Philip Graham felt that if the idea of a Minister for Children is a non starter, for the reasons clearly presented, the idea of a person similar to an ombudsman might be a more practical proposition.

Paul Boateng: This was quite a separate option which I would neither open up or close down.

- **Departmental Boundaries**

Valerie Howarth said that despite welcome efforts to get co-operation across boundaries at Ministerial level, from her experience this was not always apparent at lower levels and this led to frustrations. **Naomi Eisenstadt** added that in recent discussions with the Department for Education about Early Years Learning, they appeared to have no knowledge of the existence of Children's Services Plans at the Department of Health. **Philip Graham** felt that if the Department of Health was prepared to try to change the Home Office's approach to children, then this would be a positive step.

Paul Boateng: As regards the first two comments, I would agree that there is a need for change. We all need to think of innovative ways of working together on the ground. I can see signs of it beginning to happen, but we must not be complacent about it and we will need all of you to help us to succeed. As regards the latter comment, I do not intend to approach the Home Office about their juvenile justice system in the way I think was suggested. Life for many of our vulnerable young people is hell, due to the high levels of juvenile crime, violence and bullying on the streets. The Government will not tolerate the abuse and intimidation of young people by other young people. The interests of young children demands an effective juvenile justice system in any civilised society and we are determined to get it by working co-operatively together across Departments.

- **Mental Health Practice**

Alan Cooklin commented that the Department of Health has produced many booklets, lists etc. which health trusts could choose to follow or not, but had never stated clearly what is good mental health practice in relation to social, ethnic, cultural and family contexts. Also to achieve the main aims of this conference would require the training of many people, and this is where the Government should co-operate with the Royal College of Psychiatrists, in agreeing what constitutes good practice, which the College can then pursue.

Paul Boateng: Government has an objective to restore the credibility of the mental health service as perceived by ordinary people. We all know that Care in the Community is less than successful. There is no doubt that we need to ensure a greater clarity of purpose and objectives and I look forward to working on these with the Royal College, amongst others. You are right, we must promulgate good practice and ensure it has maximum effect on the ground.

- **Training of Social Workers**

Paul Collins and Jane Aldgate raised the question about the proper training to high professional standards of social workers who will have to bear the brunt of the work we have heard about for improving services, not only for children in acute crisis but for the many children who do not qualify for intervention under the Children Act. **Elizabeth Haslam** also raised the issue of the three year training of social workers to degree level, which had been the subject of an earlier Michael Sieff Foundation conference (November 1995). There were valid reasons for this need which did not necessarily require extra funding.

Paul Boateng: We have as you know embarked upon a review of CCETSW, to bring about fundamental changes in the training and registration of social workers, as well as the development and practice of social work as a

profession. We wish to develop more effectively the involvement and confidence, not only of social workers and academics but equally importantly, of users. We shall be looking at a relationship with local authorities and with central Government which puts training at the heart of what we seek to achieve.

One cannot separate training and education from the fact that there is a real resource issue here that I have to address. I am opposed to three year training of social workers. Instead we have to provide in-service training and recognise the challenge of adding real value to post qualifying training. Also we have the provision for better training for carers and non qualified workers to develop. All these are resource issues. Health care professionals have an equal need for training in this area alongside social care professionals. This morning I was dealing with the training of mental health care workers in special hospitals and medium secure units. Many of these workers are unqualified and many are casual, the amount of the latter I would like to see reduced. This also has resource implications.

As I said in my talk there are opportunities for new money and I would urge those within the vitally important voluntary sector, to utilise these opportunities to address the concerns I have mentioned.

16. Summary of Conference Recommendations

From the many ideas discussed by the five groups, a number of major recommendations were made. These recommendations must be considered in the context of building healthy, sustainable communities, promoting good mental health practices and preventing mental health problems in children, young people and adults. The positive promotion of good parenting, must become a part of this strategy, since "think family" is seen to be an important concept in any new policies.

Managing Confidentiality Issues

The conference felt that any professional who, in the course of their work, comes into the possession of information which could have a significant bearing on the welfare of a child, should be under an obligation to communicate this information effectively to the appropriate agency (i.e. Social Services).

A multi-professional Working Party should be set up to examine this and the many other complex issues of confidentiality, to develop common policies and procedures, which should then be incorporated into the Department of Health's revision of Working Together. Any new proposals should then be actively targeted at appropriate professionals and agencies concerned, both statutory and voluntary, including adult mental health services. The Family Law Advisory Committee should monitor the operation of these confidentiality principles, to ensure they are working in the interests of children.

Access to Services

There should be joint commissioning of adult - child mental health services within the Department of Health, within local authorities and across agency services.

There also needs to be a comprehensive development of universally accessible services, at primary level (perinatal programmes using health visitors and midwives), at secondary level (such as highlighted by Lambeth, Bath and the Mellow Parenting Project as well as voluntary agencies), and at tertiary level (Mother and Baby Units and Family Units). All services should be aware of adult mental health and children's issues, including knowledge about alcohol and substance abuse and have the skills to respond appropriately.

Information must be provided, at community level, for young people affected by adult mental health or adult disability issues, possibly through existing helpline providers.

CPA forms should include information on children and the impact of adult mental health problems on the child.

Training

At all stages and levels of training in relation to work with Adult Mental Ill Health, Learning Disability and other vulnerable adults, the existence of their children and families should be acknowledged, including their social, ethnic and cultural environment. Employers should also integrate training initiatives within and across disciplines to avoid duplication and to enhance inter-disciplinary learning.

All disciplines working with Parental Mental Ill Health and Learning Disabilities with children and families should be required to attend Continuing Professional Development programmes. Examples of good practice with CPD from across the UK and Europe could be integrated and made available locally. Regional CPD Advisors could be involved in the planning of local multi-disciplinary training programmes.

ACPCs could be renamed 'Area Child Welfare Committees' and could be asked to address the needs of vulnerable children and children of Mentally Ill or Learning Disabled Parents, and include a representative from the Adult Mental Health Services.

It was recommended that a new **General Social Work Council** be created to set standards and to promote and monitor social work training. Such a Council would provide a better professional context for Social Work practitioners and would allow the monitoring of standards in relation to complex Mental Health, Learning Disability and Child and Family work.

Managing the Boundaries

Boundaries are necessary but they should be "soft", with the degrees of softening set at ministerial level. Managers should encourage creative partnerships and flexibility for professionals to work across boundaries. A prerequisite for working across boundaries is the need to have, within and between agencies, an evidence based and evolving common framework and language, which takes account of both genetic and psycho-social factors including culture, race, poverty and other aspects of difference.

All workers in both statutory, voluntary and private agencies should be aware of the limits of their own competence and must be prepared and know who to refer on to. This is particularly so in the recognition and identification of situations which are "high risk" for families, and where there needs to be multi-agency involvement. These are not necessarily formal child protection situations, e.g. the suicide of a parent.

There is a need for more joint funding between Children's Services Plans, Community Care Plans and Early Years Development Plans. Barriers which prohibit the financing of joint work should be identified and removed. This would, amongst other things, make it easier to offer services and support over longer periods.

New Structures for Old

In discussing all of the above recommendations, we are considering a spectrum of needs, some of which may require similar and some different responses. Could other conditions, e.g. physical illness, be included in the spectrum, thus reducing the stigma attached to mental ill health when treated alone?

We are not recommending major structural changes, rather the need to make communication, liaison and joint working more effective. We must avoid the danger of concentrating on heavy end cases to the detriment of the greater number of less extreme cases.

Consideration should be given to practise based research in order to establish what works in relation to practical outcomes. There could then be a national statement regarding best practice and standards, which could then be debated and the results adopted locally. Each professional body should review its Code of Practice, in the light of these guidelines, and ensure that it reflects multi-disciplinary working and the broad social context of work in this area.

There is a need to promote stability and retain staff. Single case audit could be a mechanism for considering the implications of how we work. If hard pressed staff are to take on additional demands attention must be paid to improved staff care, including space for reflective practice and non crisis work.

17. THE RESPONSE OF THE NHS EXECUTIVE

Bob Jezzard, Senior Policy Adviser, Women and Children's Health Services Branch, started by saying how delighted he was to have been involved in the organisation of the conference since it had been a theme close to his heart since he first went to the Department of Health. After he had read many Part 8 Reviews, primarily following child deaths, he had been struck by the number, which mentioned mental health problems in adults. Adrian Falkov was asked to look at these Reviews in more depth, and this had brought more focus within the Department itself. Shortly afterwards the Royal College of Psychiatrists had published a report which stated that 15% of the homicides committed by mentally ill adults are homicides of children. Therefore, Bob Jezzard continued, they had received evidence from two different perspectives, that a new focus was needed. He went on to explain how this had been addressed.

Just over a year ago, the Department had an internal meeting to bring together the Social Care Group responsible for children, Adult Mental Health and Child Care Policy representatives and also the Department for Education and Employment, to explore some of these issues. It had been clear that there was an all round commitment to progress.

Initiatives

We have to try and progress these issues so that they are owned by all the professional groups. The best approach is to try and encourage people to think, ".....how can we raise the awareness of children's needs, what do we need to do?" This conference has been a very good focus for this. It is also worth announcing that shortly, with support from Elizabeth Johnson's group, there is going to be a multi-disciplinary working party set up, primarily to address training issues in this particular field. Clearly this working party needs to involve the ADSS, Child and Adult professionals, representatives from the primary care sector and possibly some voluntary sector representation as well. Getting the balance right in terms of composition will not be easy because there will be many people who want to have an input, but to be most effective, it needs to be small.

Recently we commissioned the development of a training pack for mental health professionals on this very issue. Reba Bahduri, from the Social Services Inspectorate is taking the lead and the pack should be ready by early summer 1998. The Department will also shortly have its annual meeting with the Royal College of Psychiatrists and this issue will be on the agenda. It is terribly important and I am very conscious of the commitment that John Cox, an Adult Psychiatrist and Dean of the College, has demonstrated in thinking about the needs of children. However, what we really must do is to take it further into the field of day to day adult mental health so that everybody is thinking in a similar way. This is by no means a straight forward issue, getting everybody to shift their attitude and increase their awareness at the same time.

Structures

Some people feel that somehow a new structure will solve a problem, but I am not terribly convinced. Until quite recently Child Mental Health policy was situated within the Mental Health Branch of the NHS Executive, so I worked closely with colleagues in Adult Mental Health and Mental Health for the Elderly and Mental Health for Learning Disabilities and we've always had close links with Social Care. In fact, the number of possible links which can be established within Government Departments is quite large and this can often make it more difficult to keep in touch. Since the Health Select Committee report on Child and Adolescent Mental Health Services recommended a greater integration of Child Health, I am now within a Child Health branch integrating all child health functions. This does not solve all the problems. These are cross boundary issues which new structures do not always solve. Efficient networking by individuals is the real key.

Projects

I would like to draw attention to some of the initiatives and projects that have emerged during this conference. I think there many ideas to take away with you. It is worthwhile considering the factors that prompted such interest. Sometimes it is anxiety or a tragedy that gets people working together. Some ideas for joint working have been around for quite a long while, but now is the time for us to capitalise on those developments. Everyone should go back to their own services and ask, "If it can happen there, why can't it happen here?" Using models of good practice is a useful and important focus.

Finally, I would like to comment on the Minister's speech last night. He talked a great deal about the family, about parenting, the importance of children, and of the context in which parents can exercise their rights and responsibilities. He also talked about giving Child Mental Health a higher profile and about early intervention. The importance of a conference like this is to tune your ears to these ideas and to consider ways to progress them.

Martin Brown, Head of Mental Health and Learning Disabilities Branch, continued the response by saying he was sorry he had been unable to attend the whole of the conference, but had found it useful to have heard the Minister's speech the previous night and to hear some of the concerns and issues that were raised with him. He also said he would be exploring some of these issues and hoped that we can all think of ways to do better.

I would firstly like to say a little about Adult Mental Health and its policy framework. Our perception in the Department is that the policy framework for Adult Mental Health is relatively clear, though some might challenge this. New policies in Mental Health over the last two to three years has been minimal, while we have attempted to get people to implement existing policy directions.

Policy

The broad policy framework is that there should be local, comprehensive services for the vast majority of people who have mental health needs. There will always be a minority who need high or medium security but the vast majority of people should get help as close to their local communities as possible. How are we really doing, as regards Mental Health Policy? I think it is fair to say that we are not doing quite as well as we would wish but maybe not as badly as we feared. We are making imperfect progress towards that ideal of comprehensive services but there is still a great deal of work to do. There is considerable commitment from people involved and a tremendous amount of good practice developing locally, which is sometimes underestimated. On the negative side you might find a work force that is under substantial pressure, morale is not good, they feel overworked and overburdened and some of that is a direct result of Government policy which may need amending. There are shortages of staff, shortages of resources, and never enough money to go round.

Demands for Services

The demand for Mental Health Services, particularly Adult Mental Health Services, is now the fastest growing part of the Health Service and far outweighs demand for any other service. As we understand more about the real problems that people have in society, it is likely that demand is always going to increase. So we have a clear challenge - are we always going to be trying to catch up with some ideal that we will never actually reach? We must become more effective in what we do, particularly across boundaries. In London and in other cities, the pressures on acute services are substantial and create major problems that we must resolve. We have made a start in this direction and I would be happy to say more about that if required.

Care Programme Approach, or CPA

I do want to say a few words about the important concept of CPA, which was developed as a consequence of the Isobel Swartz enquiry at Bexley in the early 70's, where a patient murdered a social worker in Bexley Hospital. The enquiry team said that it was clear that there was no decent assessment of the individual's needs, or the problems and risks that they might present. There did not seem to be a plan of care, people had not talked to other professionals or shared information. There appeared to be no evaluation of the individual's progress or even discussion amongst the professionals about how this individual had died. They further recommend that use must be made of good practice guidelines, which already existed in some parts of the country for assessment planning and evaluation etc. *As a result, in 1992, the Department issued their Care Programme Approach, which immediately provoked a backlash from the service professionals questioning the Department's right to tell them how to run their professions and many refused to look at the CPA.* And there it lay for a number of years until we began to monitor severely the uptake of CPA. The CPA is a process of care and it is fair to say that the Department's Mental Health policy over the last 10 years has focused very much on *inputs*, buildings, resources etc., and trying to get the right infrastructure to provide comprehensive local services. We have focused very much on the processes of care, and what people actually do. Now, it may well be that we need to move on from those particular discussions and start to think much more creatively about *outcomes* and the differences resulting from having a CPA, or not. *A CPA is an attempt to set a framework within which people should receive the relevant care and is not an attempt to*

determine the clinical activities that take place within the context of that framework. It is now timely to consider whether we have got that right.

Future Policy

I would echo what Robert Jeppard said about those areas that the Minister highlighted in his speech, particularly his thoughts about Mental Health policy. Although new Ministers like to achieve changes rapidly, we are encouraging him to take a broader, considered view before implementing changes. Then when he is ready and we have identified the gaps in our policy and the aspects that we need to adjust, we can then produce a coherent strategic framework for the next 4 to 5 years. This would reduce any adverse effects on the service, its pressures, demands and resources.

The Minister mentioned last night the issue of public credibility and Adult Mental Health Services. Public safety aspects of Adult Mental Health Services is an important issue and is an important component of any present or future strategy. The extra dimension which is very welcome, from my point of view, is that the Minister has talked about the need for Services to be safe for individuals who are receiving care as well as for relatives, users, carers and families. So as Bob Jeppard says, there are substantial opportunities opening up to do things that, perhaps, previously we might not have been able to approach and we need to take those opportunities while we can.

In closing I would like to say that I support many of the aspirations that came out from the working groups. The challenge is to translate them into changes at local level. We as a Department can't do this by dictat. We have to find a managed approach in which there are incentives for people in Adult Mental Health Services to work better and closer with Child and Adolescent Mental Health Services. The challenge is finding the incentives rather than presenting them as demands. So if there is a consensus amongst the professional bodies working in the field that changes would be a good thing, then it is much easier for the Government to give overall guidance. Neither, however important it seems, is it sufficient for professionals to try and sort it out themselves because often when you run up against boundaries with other care groups, doubts and hesitation creeps in about actions and policy. So we have to make sure that we are co-ordinated, and the practical changes that we want to make will make a difference.

Elizabeth Johnson, Head of Children's Services, concluded by saying that the conference theme was very dear to her heart, since she had been responsible, a number of years ago, for the Mental Health Act. She particularly remembered the Falkov report summarising the Part 8 Reviews, which highlighted how better working with mentally ill adults could really prevent child deaths. She commented that there were few areas where the results could be so clear cut. That important subject had been her starting point and she was very glad it was being addressed.

I do not have much more to add to what Bob and Martin have already said, because they and we in the Social Care Group are working on a common agenda. However, I wish to reinforce three particular points that they both made and indeed were also made in the first session this morning. The first, is looking at priorities in work and being realistic about your own and other peoples agendas. Over the last few years, during our work on refocusing children's services, one of the few categories that always arises has been children who come from homes where there are mentally ill parents. Another category is children with mental illness problems themselves and as part of this refocusing debate, this area will continue to be pushed to the fore. Interestingly, the Comprehensive Spending Review, which is taking up an incalculable amount of Whitehall time at the moment, is throwing up similar issues when looking at priority areas where we really can make a difference. So I can reassure you that it is an area in which we are all looking for results. However, we do have to be realistic, all Government Departments have their own new Ministers pushing them in new directions. As I have said at previous Sieff Conferences, we do have to make sure that we get the most effective results possible from the inter-agency working we do.

Inter-agency working across boundaries is something that is growing in importance and more and more is starting to be done. In the Social Care Group at the moment much of our work is now jointly with other Departments. For example, we are working so closely at the moment with DfEE on the Early Years Work and Early Excellence Centres etc., that we are seriously considering moving some staff into DfEE! Others of my staff spend most of their time talking to the Home Office about joint agendas for protecting children from abuse, looking at juvenile justice and young criminality elements and also the whole area of domestic violence which is growing in importance. The issue of personality disorders, touched on this morning, has been the subject of discussions between the Government and Ministers, concerning the need to have a joint approach to what is seen as a fairly

fundamental problem in society and which has an enormous impact on children. The Health Action Zones, although being set up on the Health Service side, will again be looking to other services as well to tackle problems which people realise need inter-agency action. So the door is opening to more inter-agency work and this will be encouraged.

My final point has been mentioned earlier, but I feel it is important enough to warrant re-emphasising. Do build on the current priorities of the new Government and push at open doors. Don't waste time banging heads on closed doors. When so much of your agenda is really in tune with Government thinking, it perhaps needs to be steered more towards possible solutions and practical steps forward. For example, the Welfare to Work Programme is absolutely fundamental to the Government's credibility but if whole groups of children, whether it's disabled children, abused children, children in care, or children who come from some kind of disadvantaged background, are not seen to be benefiting that is going to be enormously damaging to the credibility of the whole programme. They are aware of this and, therefore, such children are being targeted as priority areas and this actually gives access to new funding which is not available from existing budgets.

The emphasis of the Government on social exclusion, their concerns about the development of a permanent disadvantaged under class, the enormous emphasis on preventive work and early years development is of great concern across Government and is another area that can be tapped into. *The tremendous emphasis on education allows us to demonstrate that it is pointless providing good schools if there are many disadvantaged children who simply can't benefit from them without support and help.* That is another message that the Government is prepared to listen to because they want all children to have access to education and opportunity. So I would urge you to take the conclusions of this Conference forward and continue your dialogue with Ministers and with all Departments of Central Government about these issues so that we can work together to tackle some of these problems.

Summary of Major Discussion Topics which followed:

- **Care Programme Approach, or CPA**

The Department of Health acknowledged that difficulties had been encountered in bringing about the changes at local level, which the CPA intended, partly due to their guidelines being taken as statutory without clearly describing many of the outcomes or processes that could and should occur. There needs to be a more fundamental look at how these processes enhance clinical care and how one makes such judgements and how other important issues such as early intervention, promotion, health education etc. integrate at local level, without leading to ambiguity and misinterpretation in the field.

- **Children In Need**

The definition of Children in Need is not readily understood by many professionals and is part of a Departmental review as to how Central Government and Local Authorities interpret their separate responsibilities. The potentially amorphous term, without clear boundaries, needs more focusing and thought, particularly about how drug addiction, learning disability, and physical illness are broadly related to parental health issues. Recent research is suggesting that in this latter area, Local Authorities are performing better than was first imagined and a plea for caution was registered before any draconian changes are agreed.

- **Working Together**

Concerns were expressed about the different rules regarding confidentiality and client records, between Social Services, Health and the Voluntary Sector, and the separation of Children's Services Plans and Community Care Plans, within Local Authorities. These differences mitigate against effective Working Together. It was mentioned that the Caldicott Committee has just submitted a report to the Chief Medical Officer examining the issue of sharing of information between different professionals. The aim is to accommodate legitimate concerns about how and what information is released, whilst making sure it is used correctly by the right people. As regards Children's Services Plans particularly, The National Children's Bureau are carrying out an assessment, on behalf of the Department, to see if they are really working and what differences they make in practice.

- **Welfare To Work**

There was strong support for the Welfare To Work programme, about which the Minister is very keen. There was also strong support for this scheme to be extended to include 16 to 18 year olds leaving care, who lack parental guidance and protection and are therefore at their most vulnerable. This view will be fed into the Department's debate.

- **Prevention**

Concerns were expressed about a number of areas where prevention is an issue. Apart from the obvious early preventative work with children, which can reduce problems later, we also need to consider the impact of children's problems on adults. In addition, children with alcohol and drug abusing parents, and children exposed to domestic violence, often fall between the services of children in need and children in need of protection. There is a need for debate between the Department and those concerned as to whether it is better, as some feel, for Local Authorities rather than Government to take care of these issues.

- **Mental Health Enquiries**

There appeared to be a general consensus that Part 8 Reviews and Confidential Mental Health Enquiries needed re-aligning, to produce a system that satisfies both victims and families. A dialogue is ongoing in the Department about these processes.

- **Personality Disorders**

There are senior level discussions taking place between the Department of Health, the Home Office and the High Secure Services Commissioning Board, to produce a definitive statement which involves the criminal justice system and access to health care. Since professionals involved are themselves unsure whether *any* action can make a difference, research needs to be commissioned, aimed at identifying how and what action *can* make a difference. In this research the impact of parental personality disorders on children should not be forgotten.

18. Conclusion.

Elizabeth Haslam, in drawing the conference to a close, firstly thanked all the speakers, on behalf of the Planning Committee and the Trustees, for their excellent presentations, and was sure that the many issues they had raised, would continue to be discussed outside the conference with as much vigour as they had been inside. In thanking the delegates, she emphasised that the success of a conference is also very dependent upon them and their involvement, which in this case had been total.

She expressed gratitude again to Arnon Bentovim for the time and effort he had expended in planning the conference, and also gave a special thanks to Bob Jezzard who had been an invaluable liaison between the Foundation, The Department and many speakers and delegates. Final thanks were given to Trevor and Mary de Tute, whose work with the administrative preparation of these conferences and with the subsequent report editing and printing, are much appreciated, and to her husband who gives her great support whilst continuing his steep and bumpy learning curve!

Looking forward, we should all welcome the Ministers address, and build on its positive aspects, as well as progressing the conference issues and recommendations within our own areas of influence.

As regards the Foundation, apart from our next September conference, we intend to host two additional, important conferences. In the first, we are looking to encourage the Government to widen its Welfare to Work scheme, to include 16 to 18 year olds leaving care. The inequality with which they are treated leads many, who have no parental guidance or support, to exclusion within the community. At the same time we are hoping to encourage industrial employers, from both private and public sector, to take these children, train and employ them. However, at the last count there were nine Departments looking after children's issues and this makes any partnership initiatives between Industry and Government extremely complex. In the second, we are edging our way into the European field because we share many similar problems with Europe, and we intend to host an international

conference on a major issue. However, again we need a spokesperson for children, perhaps not a minister, but someone who can be invaluable in communicating with Governments and EEC Departments in Europe.

Delegates

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| Margaret Adcock | Independent Social Work Consultant |
| Kathleen Aitken | Manager, Swindon Mind |
| Prof. Jane Aldgate | School of Social Work, Leicester University |
| Elaine Arnold | Lecturer, Social Work and Social Policy, Sussex University |
| Karen Baistow | Centre for Comparative Social Work Studies, Brunel University |
| Claire Blackman | Health Studies Directorate, Audit Commission |
| Dr. Arnon Bentovim | Consultant Child Psychiatrist and Trustee, The Michael Sieff Foundation |
| Marianne Bentovim | Consultant Psychotherapist and Trustee, The Michael Sieff Foundation |
| Reba Bhaduri | Social Services Inspectorate, Department of Health |
| Peter Clarke | Director, ChildLine Cymru/Wales |
| Hedy Cleaver | Senior Research Fellow, Leicester University |
| Chris Cloke | Senior Policy Advisor, NSPCC |
| Dr. Alan Cooklin | Consultant to the Paediatric Liaison Services , UCL Hospitals |
| Prof. Anthony Cox | Professor of Child & Adolescent Psychiatry, Guy's and St. Thomas' Hospitals |
| Sue Creighton | Senior Research Officer , NSPCC |
| Dr. Carolyn Davies | Senior Principal Research Officer, Department of Health |
| Mary de Tute | Collator of Conference Proceedings, The Michael Sieff Foundation |
| Trevor de Tute | Administrator, The Michael Sieff Foundation |
| Dave Edwards | Director of the Family Rights Group |
| Naomi Eisenstadt | Chief Executive Family Service Units |
| Hilary Eldridge | Clinical Director, The Lucy Faithfull Foundation |
| Dr. Michele Elliott | Founder and Director of Kidscape |
| Judith Evans | Assist. Director (Legal Services) Hereford and Worcester County Council |
| Graeme Farquharson | Director, Masters Programme in Group Psychotherapy, University of Sheffield |
| Gill Gorell-Barnes | Senior Clinical Lecturer, Tavistock Clinic |
| Prof. Philip Graham | Chair, National Children's Bureau |
| Jenny Gray | Inspector, Social Services Inspectorate, Department of Health |
| Helga Hanks | Consultant Clinical Psychologist, St. James University Hospital, Leeds |
| Margaret Harrison OBE | Director and Founder of Home-Start UK |
| Lady Elizabeth Haslam | Founder and Trustee of The Michael Sieff Foundation |
| Lord Robert Haslam | Chairman of The Michael Sieff Foundation |
| Valerie Howarth | Chief Executive, ChildLine and Trustee, Michael Sieff Foundation |
| Rupert Hughes CBE | Trustee, Michael Sieff Foundation |
| Dr. George Ikkos | Consultant Psychiatrist, Barnet Psychiatric Unit |
| Peter Jefferies | Assist. Chief Probation Officer, Inner London Probation Service |
| Anne Jenkins Hansen | Director of Practice and Innovations, National NEWPIN |
| Dr. Ilan Katz | Head of Practice Development, NSPCC |
| Shaun Kelly | Child Protection Advisor, NCH Action for Children |
| Dr. Roger Kennedy | Consultant Psychotherapist, Family Unit, Cassel Hospital |
| Anne Kendal | Team Manager, Mental Health Dept., Bath & N.E. Somerset Council |
| Geoffrey Lewis | Chief Executive of the Residential Care Group Ltd. |
| Kate Mayes | Training Officer, London Borough of Southwark |
| Chris Middleton | Nurse Teacher at Nottingham University |
| Nichola Moxam | Child and Adolescent Mental Health Social Worker, Bloomfield Clinic |
| Anne Mullins | Senior Policy Officer, NCH Action for Children |
| Alison Packwood | Senior Nurse, Child Protection, United Bristol Healthcare Trust |
| Gill Parry | Senior Nurse, Child Protection, Gateshead Healthcare |
| Wendy Rose | School of Social Work, University of Leicester |
| Jane Royle | Social Services Department, Wandsworth Borough Council |
| Janet Shieff | Education Link Officer, London Borough of Croydon |
| Dr. Wendy Stainton Rodgers | Senior Lecturer in Health and Social Welfare, The Open University |
| Prof. June Thoburn | School of Social Work, University of East Anglia |
| Prof. Jane Tunstill | Professor of Social Work Studies, Keele University |
| J. van Wagtenonk | Principal Manager, Children and Families, Stockton on Tees Borough Council |
| Dr. Eileen Vizard | The Young Abusers Project, Camden and Trustee, The Michael Sieff Foundation, |
| Amy Weir | Social Worker, London Borough of Camden Social Services |
| Estela Welldon | Consultant Psychotherapist, Portman Clinic |
| Richard White | Solicitor, and Trustee of The Michael Sieff Foundation |
| Peter Wilson | Director, Young Minds |