Bridging CAMHS and social-care teams: *Experience in a 'troubled families' project*

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This article is based on our work as a team of CAMHS clinicians in the Families First pilot project, the London Borough of Newham's 'troubled families' initiative. The 'troubled families' programme (Casey, 2012; Department for Communities and Local Government, 2012) is a government initiative aiming to 'turn around' 120,000 families defined by poor school-attendance or exclusion, worklessness and anti-social or criminal behaviour (families are identified as 'troubled families' if they meet two criteria). We, a small team of clinicians, were also given a role to work closely with the children's social-care teams, as part of the department's drive to introduce systemic approaches to social work (Goodman & Trowler, 2012). We will describe our work from three perspectives; our client families', social-care colleagues' and our own. We will first describe the context of our work, our practice, experience and learning, then present a summary of a qualitative analysis of feedback we received from social-care colleagues and families.

Context of the service

The Newham Child and Family Consultation Service has been developing accessible and responsive services for over a decade (Aggett & Ryall, 2012; Aggett, 2012). It is jointly funded by health and social care and we have strong connections with the multi-agency network; outreach work takes place in many parts of our service. Dedicated CAMHS clinicians work with the local authority services (e.g. looked-after-children teams, Early Start) and in the education-outreach service in mainstream schools and special-education provisions (e.g. Metzer, 2012).

The pilot gave us an opportunity to further develop our relationship with the local authority. Our role was to be embedded, and integrated members of three social-care teams to provide a range of CAMHS input, including a liaison role, consultation, teaching and training, and therapeutic input to families known to these teams. Our model was based on our service's ethos of providing accessible, responsive and flexible CAMHS input to children, young people and their families who are often described as 'hard to engage' for a range of reasons. The plan for our project was informed by the developments in the borough, where training in systemic therapy and social-learning theory was being rolled out to all social workers. This meant there was an expectation for us to work jointly with social workers, with a hope this would provide a learning opportunity to build on the training. We also saw it as an opportunity for mutual learning, given this was the first time in Newham we had a chance to work closely with social-care teams.

Our practice

Cases referred to us often involve 'hard-to-engage' families, risks in relation to child-protection issues and mental health, the possibility of, or ongoing care-proceedings, complexities in terms of multiple problems and complex needs in children, young people and often parents, too. Our theoretical orientations are parenting interventions based on systemic therapy and social-learning theory. We used different venues, flexibly, to maximise the impact of our work. We have seen young people and their carers at their home, foster-care homes, care homes, schools, social-care offices, clinics, and even in a park, cafes and job centres. Sylvia, whose young client took her on a dog walk in a park, sometimes had to travel a long way to meet young people and carers who lived out of the borough, as many of her clients known to the youth-intervention (social care) team experienced disruption to their lives, e.g. going in and out of care, moving to live with other relatives or carers due to placement breakdowns. However, we did not define our work by home visits or 'outreach' per se, recognising the importance of flexible approaches. Our ethos is 'crossreach', a *"term to describe working across, with and in multiple contexts; purposefully working flexibly across contexts using a range of venues; working with and within the multi-agency network; working with the 'family-helpers relationship' (Imber-Black, 1988, p. 131), supported by the clinician's ability to reflect on and negotiate with clients on the most helpful approach, depending on the aim of the work at any given time"* (Totsuka, 2012, p. 1). For example, Yoko suggested meetings at a social worker's office when the family were unable to acknowledge the local authority's concerns and the seriousness of the court-mandated work. In this case, we thought the social worker's office might symbolically communicate the nature and the purpose of the work.

Although we tried to co-work with social workers whenever indicated, we quickly realised the best approach was to keep seeking feedback from the families and social workers as to what is most helpful. For example, we did not realise, until we met with a parent alone, how terrified and petrified she was of the social-care department's involvement, which was causing her to walk out of meetings, creating an impression she was not 'engaging' or cooperating. Some families seemed more able to talk openly without a social worker being present, particularly those in or at risk of care proceedings. Bella, who worked with a social work team, where most cases were in or near proceedings, in some cases found meeting with parents individually before attempting to bring the social worker and family together was a helpful approach. Whilst some families seemed to benefit from seeing social workers and clinicians work together, we were aware of the risk that joint work with social workers could make us

seem aligned with them and may lead to poor engagement from families. We found it necessary to have an ongoing dialogue with families about our role, constantly negotiating confidentiality and thinking together about what information is helpful to be shared and with whom, and how to helpfully facilitate this.

We try to work with the network as a resource to create changes for the family. However, some families, where children were on child-protection plans, found the process extremely stressful. The fear of, and anger with, the local authority's 'intrusion' often makes it hard for them to work with their social workers that, in their view, have the power to take their children away. It was helpful to reflect on the dynamics within the network and common pitfalls such as a sense of powerlessness (for both professionals and clients); expectations of chronicity and timelessness (i.e. the network losing a sense that things can be better, or things used to be different) and power relationships within the network; and we often try to work on the relationship between the family and social workers, for example, by explaining the system to the family and explaining the family to the system (Aggett *et al.*, 2007).

As part of this work, Yoko started to encourage parents to mentalise (e.g. Asen & Fonagy, 2012) their social workers. She asked them if they have heard news about child abuse or death (many parents know about 'Baby P') and explained that social workers see hundreds of families and, if one of them turns out to be like these cases on the news, they would be vilified, lose their career and have to live with the guilt for the rest of their lives. After the question, *"Imagine you are a social worker. How would you make sure the family you are working with is not one of them?"* another question *"What can you do to show your social worker that you are not one of these families on the news?"* seemed to have a different meaning and spur the families into thinking more positively how they can demonstrate their strengths to their social workers. After this discussion a parent, who was complaining about the social worker's unannounced visits, was fully convinced these visits were necessary to keep children safe and could see that the social worker was *"just doing her job"*. We try to help families build on small positive changes and credit them for the changes by emphasising that they 'earned' it; for example, positive feedback at a child-protection conference or fewer unannounced visits.

Our experience and learning

We had the privilege to work closely with dedicated and compassionate social workers and to witness the difference good social work makes. For example, a parent who kept denying physical abuse to her child, resulting in an impasse in therapeutic work, was able to acknowledge her responsibility after realising that the patient and helpful social worker was not there to take her children away. The parent then engaged with therapeutic work with us, jointly with the social worker, to think about how she could repair the damage caused to the child's emotional wellbeing and their relationship. The biggest learning for our team was the insight we gained into the challenges social workers face; for example, their caseload of extremely complex cases, engaging families who may or may not want their input (and some families who may be overtly hostile), the changing demands on their roles, the sheer number of professionals they have to keep on board and the tight timeframes in their work, sometimes dictated by courts. We realised the network (including ourselves, before this experience) do not always appreciate this. For example, when decisions on rehabilitation were made in court, against the local authority's recommendations, the network meeting was quick to question their plan without appreciating their dilemma and the power of decision-making being out of their hands.

Summer (2013), a clinician working within a local authority, encourages her social work colleagues to make purposeful use of statutory visits by thinking in advance about the situation and 'taking hypotheses' with them. As none of us have social work backgrounds, working jointly with social workers helped us understand their roles and widen our perspectives. For example, when we tagged along with a social worker's meeting with younger siblings that we were not directly working with, the fact they were happy and doing well at school seemed to indicate the strengths of the family (which we can highlight as *"something the parent is doing right"*), despite difficulties in other areas of their life. Hearing the younger children talk affectionately about their older sibling, who had serious difficulties, provided a different perspective on the young person.

Once we built relationships with social workers, we started to hear their views and experiences of our service. A common theme in their comments was that we were not responsive and accessible, partly due to waiting lists (although our recent service-re-design addressed this). We repeatedly heard social workers say they hardly see CAMHS clinicians coming out on home visits, in particular, with social workers. From our perspective, this did not seem entirely accurate, given all our colleagues offer an outreach service in response to a high level of mental health risk, and the multi-agency work is valued by the whole service. However, it was important for us to realise that there continue to be such perceptions of our service. In this sense, we tried to provide a bridge between CAMHS and social-care teams; for example, by explaining how we make decisions on urgency or the need for outreach work in the context of significant cuts to our service in recent years. We also wondered if this highlights the importance of the personal relationship with social workers, and making it possible for them to contact one of us as opposed to the 'service' (over the years, we had noticed that the availability of named or dedicated clinicians seemed to help change schools' perceptions of our service). In our role, working alongside social workers, we also provided consultation on a wider variety of cases we were not directly involved with, and we hope that such input would support the integration of therapeutic approaches and preventative work. We also encourage our local authority colleagues to attend child-mental-health training (known as 'Tier 1 Training') provided by our CAMHS.

The 'troubled families' initiative means elaborating clear and defined goals we were expected to help the families achieve. Whereas we had some successes, we were also conscious of the reality that many of the parents were unable to seek or find a job, due to physical or mental health problems or learning disabilities. We were also aware of the limitations of our team and the need for a joined-up approach with other CAMHS colleagues. Liaison with the CAMHS clinician in the young-offending team has been particularly important. Although our focus is child and adolescent mental health, we were often bringing in adult-mental-health perspectives to the network and signposted for referrals, especially in cases where adult-mental-health services were not yet involved, in order to better understand the parents' difficulties and capacity.

Feedback from social workers

As part of the evaluation of our project, clinicians who were not directly involved with them interviewed social workers and families. Seven individual or focus-group interviews were conducted with social workers and managers, using a semi-structured interview. One manager offered written feedback. Transcripts were analysed using thematic analysis. We will describe the main themes, with examples.

1. Shifting perspectives

Social workers felt consultation with the clinicians helped them think differently about cases and reflect on their practice in new ways, which moved their work forward.

"It is shifting perspective slightly away from immediate concerns and addressing child protection plans, and looking slightly more in a wider context, and shifts focus slightly which I thought was helpful."

Social workers frequently cited the clinicians' acknowledgement of the families' past and use of systemic and strengths-based approaches as helpful in expanding their own thinking. The different therapeutic theories appear to function as transferrable 'tools' or frameworks they can continue to draw on in various aspects of their future work. They described how they have used therapeutic approaches in different stages of their work, such as assessments, hypothesising and interventions.

"I am employing different approaches and attitude towards interventions with this case and others. Developing transferable skills."

2. Moving forward together

The direct work, jointly conducted by social workers and clinicians, has helped social workers move their work forward. They indicated there were a number of facets to the support provided by the clinicians that facilitated this. **Flexibility and accessibility** emerged as one of the key themes. The embedded role of clinicians made it easier for social workers to discuss, develop and implement intervention strategies with them.

"It has been good to have that consistency. X (clinician) has been able to see how cases have progressed rather than it gets missing."

Social workers found the accessible and integrated clinicians in their teams helped work to progress at a quicker rate. They felt the willingness of the clinicians to see families in their homes or social-care offices, rather than only in clinic settings, was a crucial factor in kick-starting therapeutic work with hard-to-reach families.

"You have to make arrangements for the family to go and see them (at clinic), and a lot of families won't do that, you have to bring it to them. So, the fact that she goes out is really beneficial."

"This way it also makes the family more comfortable. A family had not attended (clinic) appointments and was saying they didn't receive letters. But, X (clinician) was coming to visits I had already arranged so it was a lot more helpful than them coming all the way to the clinic as they were comfortable, because they knew me and it was in their own home. "

Social workers indicated that **outreach work** was appreciated by families and facilitated positive outcomes; for example, in engagement and helping families gain different perspectives on the issues they were facing.

"Parent totally shifted her perspective; she was engaging more, seemed to be more insightful, more self-aware. ...Really good outcomes achieved for that family."

"From my opinion it's more helpful if they are more involved as X (clinician) was coming into the family home to support the social worker – a fresh pair of eyes on the whole situation rather than just listening to the social worker's opinion."

Social workers also mentioned that families often found it easier to share information with the clinicians in response to therapeutic styles of communication. Families were less fearful when disclosing information to clinicians who were regarded as less threatening or likely to enforce unwanted measures.

Linking therapeutic theory and practice: Social workers felt joint visits with the clinicians enabled them directly to see therapeutic techniques. This in turn helped them to develop confidence in drawing on their own theoretical knowledge and using therapeutic skills in new ways. When asked which stage of support was of most value, a social worker commented:

"Joint working, as I also learned something from her especially talking with the service user. She takes time to build relationships and work systemically."

"Some questions that X (clinician) asked that I never thought about, that helped me with my other cases".

3. Challenges

One of the barriers identified by social workers was the clinicians' limited capacity. Whilst consultation was described as useful, some felt more involvement of the clinicians would have been helpful. Social workers highlighted the differences in therapeutic work and social work, in terms of timescales and focus of the work.

"We are coming from a perspective of 'change needs to be brought about'; we have timescales to do that, and we need to progress things, whereas the perspective of more therapeutic input is more ongoing and less emphasis on timescales."

"It appears as though Mum, something happened in the past, it is why she is stuck. ...I found that a bit worrying because I thought from my perspective, it's time this individual moves on. The same case can't be open forever dwelling on the past."

Feedback from families

Three families were interviewed. All the interviews involved mothers of children who were known to social-care teams and currently or previously subject to child-protection plans. One interview involved a 19-year-old sibling. Two families had previously attended the clinic. We will describe the main themes with examples.

1. Taking time

The importance of the clinicians 'taking time' came up in different ways. Families noted that therapists would take the time to listen, explain and share information. Families appreciated how much time the clinicians and social workers spent listening to them, leading to a sense that someone was truly trying to get to know them and thus understand the factors affecting them.

"They listened and spoke to me and A (son) separately and they took the time to know me and A".

Families felt the clinicians and social workers took time to explain processes and systems involved in the work, which made them feel supported, particularly at the early stages of the work.

"In the beginning I thought it'd be really hard. But X (clinician) made it much easier. She breaks everything down."

Authors (Sylvia Metzer, Yoko Totsuka, Jessica Muir and Bella Obi) in a garden of Newham CFCS, 385 Barking Road, designed and created by young people who attend DOST, Centre for Young Refugees & Migrants in Newham (Photo: Brigitte Wilkinson).

"She was really supportive, right from the start. They explained everything to me, everything (laughs) and she did what she said she would do."

Taking time to explain things, to be interpreters of information, seems to break down the barriers and create alliances between workers and families. This indicates that families may have felt alienated in the past by professional terminology, and anxious because they were unsure how the social-care systems that they were embroiled in worked.

"X (clinician) can help explain all the big professional words the social workers use."

"It really helps having X there to explain things to us, as social workers just say 'this is going to happen next' whereas X breaks it down and explains 'they can only do that if this and this happens first.'"

Taking time to share information and be transparent: One family emphasised how much they valued the time the clinician and social worker took to share their reports for meetings.

"They told me what they were putting in the reports before meetings and everything was right and it wasn't unfair, I wouldn't need to change anything."

This contrasted with earlier experiences where this mother felt workers were taking events out of context and adding them to reports without prior discussion, leading to her fear her children would be taken away.

2. Flexibility and responsiveness

A second theme, interrelated to the first theme, is the importance of worker flexibility and responsiveness. Families valued the clinicians' and social workers' willingness to meet in places where they felt comfortable, such as their own home.

"It's not as uncomfortable as it is at the clinic. There it feels like you're being judged. But X comes to our home and she doesn't judge us" (sibling).

"X comes to my home and asked how I was feeling. But I preferred to go to the office. I felt, what's the word, not safe, exactly, but more able to talk ... She's very understanding, willing to help."

"They called out to the home at different times of the day and evening, so they could see how things were at different times, such as when he was tired, which was helpful."

The families also commented on the flexibility, responsiveness and accessibility in relation to communication, and who was included in the work.

"She (clinician) *was always there for me if I needed someone to talk to. If I was losing confidence or just needed someone to check in with about how something was going. She wasn't just there for my kids – she was there for me too."*

3. Not being judged

The combination of taking time to get to know families and a flexible, responsive approach appeared to generate a sense

within families that the therapists and social workers were understanding them and not judging them. Some families have felt judged negatively in the past by professionals but, in contrast, they felt viewed positively by the clinicians.

"It's so different from the clinic. There, I feel like we're being judged by everyone – even the receptionists... With X, she sees how things really are in our own home, and I can ring her whenever I need to for support."

"She's not stuck up. She sees that everyone has their own problems. When we talked about mum and drugs she said 'That's something people go through in life', she didn't judge us" (sibling).

"I really liked X, she is understanding for one, and for two, she doesn't make her own judgement, she is fair, she says it as she sees it."

"They did not make me feel like I was a bad parent; the previous workers asked me too many questions about me and not A (son) and didn't see what was really going on, as they met me and A at the clinic A would often refuse to come. This meant that A was seeing no one."

The parent who made that last comment felt professionals in the past *"were judging without being there"*. When asked what she would say to other families, she said, *"They can help you without judging you. People should know that you can't change if you don't think staff are fair"*.

4. The benefits of different perspectives

All families spoke of how they valued gaining different perspectives provided by the clinicians and social workers in joint work.

"It was good to have a new social worker and psychologist together. They both saw what was going on and they were both from other places ... you are not being judged by just one person."

"It's not good cop bad cop but X will explain, whereas social services are more blunt. [Having a therapist working alongside a social worker] takes the scare factor away."

5. Solid Outcomes

Families spoke of positive and tangible outcomes they achieved which improved their wellbeing.

"X helped me to think about how I talk and act in front of the kids."

"If I hadn't seen X, my daughter would probably be in care right now."

"My daughters are a lot calmer and so am I. My little one behaves better, attends school regularly- and usually on time too!"

Moving forward

Our team has expanded since the pilot, with new developments in the local authority services. The recent changes in the wider context have included the reduction in expert-witness assessments and a tighter timeframe for care proceedings. In response, we are looking at ways effectively to support the 'front-loaded' work the local authority needs to undertake before initiating care proceedings. Such work will inevitably bring challenges; e.g. confidentiality, consent, clarity about our role as therapists, likely requests for reports on our work for courts and the potential impact of this on the therapeutic relationship (Santin, this issue, discusses these dilemmas) and the need to work within timeframes to test parents' capacity to change (which was identified as a challenge in the aforementioned social workers' comments). However, we also see this as an opportunity to further develop our practice and partnership working, aiming to reduce risks to children and young people.

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