Clinical Innovations in Children’s Social Care

SW:WFF Clinical Team
Pamela Parker
Clinical Lead for Psychology
Development of the Service

Reclaiming Social Work

Cambridgeshire Unit Model
Context

Overarching Aims:
Support the development of systemic social work practice across each function
Offer a clinical lens to systemic social work practice
Offer evidence based interventions to reduce risk and improve outcomes for children and families
Clinical Priorities

Access Function

Focus is on supporting the social work unit assessment of risk and care planning

Brief direct interventions offered include VIG, couple work, psychoeducation

Identifying needs and signposting to other services
Clinical Priorities Cont’d.

Child In Need
Assessments of Capacity for Change
Family Work
Non Violent Resistance
Circle of Security
Video Interactive Guidance
Couple Work
EMDR
Clinical Priorities Cont’d.

LAC /ADOPTION

Foster carer consultation & training

Mentalization based workshops

Limited Individual Therapy – In county only (Narrative, CBT, CAT)

Contribute to assessment and care planning

Occasional family work as part of rehab home
Clinical Priorities Cont’d.

Children with Disabilities
CWD units cover all three functions therefore with support from colleagues offer the same range of work for families of children with disabilities

Safeguarding CWD
SIG and Current Research

DVA Pathway
VIG Project
UASC Task and Finish Group
Collaboration with AFC on MBT-F with CORAM
Mentalization based approaches for LAC – submitted for publication
Siblings Together – Qualitative Research Project
Specialist placements for Trainee Clinical Psychologists
And lots more..................
Current Challenges

• Unprecedented cost savings to be made
• Ethical dilemmas & contextual forces
• Re-organisation
• Sustaining partnership working
• Focusing the clinical task and retaining ownership of this
• Evaluating and demonstrating effectiveness
Systemic Formulation in Children’s Social Care

Matt Beeke

4th October 2016
Aims

• To explain the process of how systemic formulations are made with families recently open to social care

• To explore the impact of this on the well-being of children and young people
Context

• Working as a clinician in ‘unit’ of social workers

• Highest context is risk

• Workings within the ‘Reclaiming Social Work’ model (Goodman & Trowler, 2011)
Context

• Working in Access i.e. families recently open to social care – assessment and short-term - Section 17 or Section 47 – throughput!

• Up to 12 weeks

• Issues include parental drug / alcohol misuse, domestic abuse, homeless teenagers, parental mental health, incident / disclosure of abuse, family crisis, ongoing neglect, difficulties in managing behaviour safely
Supporting systemic formulation

• Tendency to ‘action’ due to anxiety around risk and / or busyness of unit and / or need for throughput

• Can lead to unfocused assessment or assessment that ‘skims the surface’

• Aim to inform assessment questions and think about systemic context in which risk originated – second order change
What is a systemic hypothesis?

- Does not lend itself to being ‘proved’ as ‘true’ but can be evaluated on its usefulness in understanding what is happening in a family and / or bringing about positive change – pragmatic

- Keeps us in the ‘domain of explanation’ rather than the ‘domain of production’
What is a systemic hypothesis?

• Considers the context - Social GRRAACCESS – power and difference

• May take account of the family life cycle

• Takes account of resilience and protective factors within systems
What is a systemic hypothesis?

◆ Considers temporal patterning of concerns / risks – why now?

◆ Considers who in the family is most likely to want change and who may be less likely to want change
Why hypothesise?

◆ Provides a rationale for the work that we *do* with the family – can be formulated with very little information

◆ Creates efficiency by giving a clear focus to our questioning
Systemic hypothesising

- Must be helpful to the task of assessment and short-term intervention
- Must address the identified *risks*
- Must provide a helpful context for the social workers assessment of the family
- Is often initially based on very limited information
Underlying assumptions for hypothesising

• Everyone’s is behaving in a way that in some way makes sense to them within their systemic context
Why hypothesise?

• Helps provide rich information for assessment

• Creates a record of how our thinking about a family develops over time
A question that the hypothesis might answer

What is happening / has happened in and around this family that has led to the current risks that have been identified at this time?
The child in context

Bronfenbrenner (1979)
The family context – Social GRRAACCESS (Burnham, 1992; Roper-Hall 1998)

- Gender
- Race
- Religion
- Age
- Ability
- Class
- Culture
- Ethnicity
- Sexuality
- Spirituality
Other tools for formulation

• Genogram to look for inter-generational pattern

• Discussion in unit meeting and/or joint visits with social workers

• Consultation with social workers, families, schools, other professionals
System theory and mediated learning

• General system theory (Bertalanffy, 1968)
• Systems need resources and are subject to atrophy
• Families are (usually) open systems
• Exploring the family’s ZPD
• What is the minimum support this family needs to return to adequate functioning?
Link to well-being

◆ Exploration of ‘problems’ (and hypotheses / solutions) consider child in context

◆ Considers whether child’s ‘problem’ reflects issues within the system – can deconstruct scapegoating and problem-focused narrative addressing issues of power and introducing hope
Link to well-being

◆ Considers resources needed for system and child

◆ Provides opportunities for mediated learning

◆ Builds capacity, independence by not over-supporting family
Mentalisation Workshop
Sara Katsukunya,
Looked After Children.
What is mentalisation?

• Peter Fonargy first introduced the term in his work with people with Borderline Personality Disorder.

• Mentalisation helps us to understand why people do the things they do and why we do the things we do. Helps us to read ourselves and other people – it is the basis of making relationships.

• Helps us *organise* our thinking and feelings - helps us with self regulation and affect regulation.

• Acknowledgement that we can never ‘know’ for certain what is going through someone else’s mind – if we are too certain, we are not mentalising.
Mentalization

Arousal / stress response
Attachment systems activated
Why our children may struggle with mentalising

• Without a consistent, safe and positive early caregiving experience, many looked after children experience:
  • Difficulties understanding their own thoughts and emotions
  • Difficulties understanding other people’s thoughts and emotions
  • Preoccupation / anxiety with relationships and attention
  • Reluctance to rely on others
  • Becoming overwhelmed by emotions
  • Feeling unsure of their identity – what do they think?
About the workshop

• Run for children and their foster carers, kinship carers and adopters
• Facilitated by 3 or 4 clinicians (Clinical Psychologists, Assistants and Trainees).

• Several incarnations
  • Initially 6 week course, duration of 90 minutes. Children and carers separated.
  • Full day, carers and children together
  • Pre sessions for carers then full day carers and children
  • Pre session for carers, two half day workshops for carers and children, one post session for carers

• Approximately 6 carers and 6 children, age 8 – 12 (ish)
• Compliments envelopes for the children – everyone fills in throughout the workshops.

• Measures for carers pre and post. Carer
  • Questionnaire and Mentalisation checklist
Group Content

• ‘Borrowed’ from Inside Out
  • Watched clips to introduce emotions
  • Clips to ‘predict’ what is the internal experience of the characters
  • Characters on the walls – all move to stand near the emotions for different scenarios (e.g. you get to chose dessert, or it’s Christmas morning etc.).
  • Introduce scaling, and the possibility of feeling more than one emotion at a time

• Psychoeducation – fight / flight / freeze

• Body mapping – draw around body and map - where do they experience feelings?

• Dyad work – guess the emotions on your partners face, talk through scenarios of different emotions

• Mentalisation games – draw an imagined monster in your partners mind, Q and A's about my carer.

• Relaxation – progressive muscle relaxation, mindfulness exercises
Discussion with group attendee:

Helen Wielesiuk, Foster Carer.
Post workshop qualitative feedback

• **Relationships between carer and child**
  • More openness, which has led to more ‘difficult’ conversations, which has led to increased trust and sense of safety
  • Mentalising together for other people – real life examples of confusing behaviour of others
  • Validation that it is okay to feel different emotions at the same time, and different emotions compared to other people.

• **Behaviour of carer**
  • Carers are thinking more about how to phrase questions – being more careful and curious
  • Picking the moments more carefully – not rushing in with own aims if child is not in the mood for a conversation (e.g. when hungry, tired, busy etc.).
  • Mentalising more often / naturally

• **Group format**
  • Learn from others experiences
  • Peer support element – not ‘in it alone’ and others struggle with similar difficulties and that is okay.
  • Feedback and validation from others – compliments envelopes – others ‘noticing’
  • Modelling – children learning from each other
  • Eye opening – seeing other peoples experiences
Reflections and Dilemmas

• If the child is not feeling safe, it can be quite a difficult group for them – has to be carefully managed with facilitators explicitly modelling their own mentalising – coming to the group is a big risk for our children to take.

• Care needs to be taken to support carers who may be feeling anxious / struggling with concepts

• Foster carer V adopters. Element of FC being semi professional and needing to do a ‘good job’ with element of potential appraisal V adopters potentially being more relaxed and open to support?

• Measuring change quantitatively has been difficult. Different measures have been used for the different workshops, and numbers are low so not statistically significant.

• Not measuring pseudomentalising.

• Would like to capture the child’s experience – hoping to video feedback from them.
Foundations for Attachment:

Piloting a Therapeutic Parenting Group for Adoptive Parents

Dr Joanne Peterkin, Clinical Psychologist
Research Pilot with Kim Golding
Aims

• Overview of the programme and it’s aims for families
• Developing practice: What has this added to our clinical offer
• Outcomes and evaluation
• Lessons learned
• Abbreviated version of Kim Golding’s 18-week Nurturing Attachments Programme
• Aimed at adoptive parents (or foster carers) earlier on in their journey
• DDP informed programme (Dyadic Developmental Psychotherapy)
• Focused around challenges of parenting children whose capacity to emotionally connect has been compromised.
Foundations for Attachment

- Module 1: Understanding challenges of parenting
- Module 2: Therapeutic Parenting
- Module 3: Looking after yourself

- Therapeutic group: safe space for learning, reflecting, thinking about themselves and their children.
- Interactive learning, scenario based reflective discussions, practice exercises, group discussions, space for personal reflections, check-ins.
- Activity sheets and hand-outs
Group format

• Offered to adoptive parents with children aged 2 to 12
• Offered up to 10 places on each course
• Run as 6 half days (3 hours) over 6 weeks
• Additional 2 hour introduction session utilised
• Clinical Psychologist, supported by Trainee or Assistant Psychologist
• Consideration given to the group mix and dynamics
Rationale

- To support capacity issues
- To support early intervention
- Enhancing universal offer to adopters
- Ensuring adopters have a comparable level of understanding prior to more individualised support (if required)
- Hopeful about the level of support and validation that may come from peers

- But....concerned about uptake, drop out and the complexities of group dynamics which can emerge
• Opportunity to be part of the pilot project for Kim Golding’s newly developed group
• Aware of excellent feedback on Nurturing Attachments
• 18 week programme felt to be too time intensive given capacity at the time
Aims for parents

• Gain an understanding of these challenges and explore ways of building emotional connections with your children - increase trust, leading to increased attachment security and reduced levels of shame.

• Understand how to provide support for behaviour alongside building these connections.

• Understand the importance of looking after yourself,

• Understand the significance of exploring your own attachment history
Key concerns?

• Uptake:
  • Each group has had sufficient numbers attend
  • Majority of families report being happy to attend a group
  • Some struggle with daytime groups
  • Ideal when both parents attend but not always feasible

• Drop out:
  • Minimal
  • 2 drop outs to date: 1 due to work commitments, 1 felt they had covered some of the theory previously

• Group dynamics:
  • Exceptionally positive experience of running and delivering these groups
  • Groups have been varied (age and stage of child, family make-up, presenting difficulties, longevity of difficulties) but this has been manageable for the facilitator
  • Highly supportive groups with each continuing to meet informally in some way allowing for ongoing peer support.

• 6 of 22 have sought additional support since completing the group: 2 consultation, 1 therapeutic life story work, 1 additional assessment, 2 individualised support to implement ideas within sibling groups.
Sample

• 3 groups completed to date
• Total number of attendees starting the groups: 24
• Total number of attendees completing the groups: 22
• Number of completed data sets: 14

• 4th group currently underway
Demographics

• Parents attending group: 71% female
• 79% within 40-50y age group
• Average age of children: 5y5m
• 71% of children female
• Average length of time within family: 2y 7m
The Experience of Attendees: Qualitative feedback

- What changes, if any, have you perceived in yourself, your child or in your relationships?

“I have been more able to emotionally reflect rather than ‘tell off.’”
“I’ve been able to get my child to verbalise his hidden needs and emotions.”
“I’ve been able to stop getting hung up on control battles”
“I’ve reflected on my own parenting strategies and the influence of my own experience of being parented.”
“I am using PACE as part of my parenting which is very beneficial; This has had a good effect on my daughter.”
“Myself a lot more ‘in control’ of our home situation, acceptance of how things are, ability to move on from stressful situations without the need to over analyse.”
“A better ability to ‘repair’ my relationship with my son when needed.”
“Family life is a lot less stressful.”
“Training has come at a moment of ‘struggle’ for my son - so it has fed well into our developing of different parenting strategies / styles to help him and the rest of the family cope.”
The Experience of Attendees: Qualitative feedback

• What was helpful about the service you received?

“Good mix of theory and personal experience.”
“Learning how other parents cope and what can be difficult.”
“I found the staff to be non-judgemental and knowledgeable, as the psychologists admit their own imperfections within family interactions.”
“Meeting others in the group who are experiencing similar situations.”
“Useful strategies to apply at home which work.”
“A chance to reflect on experiences and explore different ways to approach things.”
“The ‘house model’ of parenting – learning about blocked trust and care as well as more on PACE and therapeutic approach – insightful!”
“Sharing stories / ideas / support.”
The Experience of Attendees: Qualitative feedback

• What would you like to see change or improve about the service you received?

“Great course. I would be happy if there were more sessions, or options for individual follow-ups with the psychologist, e.g., 30 minutes one-to-one at three months, six months and one year follow-up.”

“Timing was difficult to fit around work / child care – evening sessions?”

“Advertise these courses more widely – not reaching all that could benefit!”

“Would have been great to have this at an earlier stage”
Outcome Data

• Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
• Brief Parental Self-Efficacy Scale
• Parental Reflective Functioning Questionnaire
• Carer Questionnaire
• Assessment Checklist for Children/Pre-schoolers

• Small numbers allowing insight into trends only
The Warwick-Edinburgh Mental Well-Being Scale

The Warwick-Edinburgh Mental Well-Being Scale at Time 1 (pre) and Time 2 (post)
The Brief Parental Self-Efficacy Scale at Time 1 (pre) and Time 2 (post)
The Carers Questionnaire

The Carers Questionnaire at Time 1 (pre) and Time 2 (post)
Assessment Checklist for Children - Short Form:
Total Scores at T1 (pre) and T2 (post)

- **TIME 1:**
  - 60% children had total scores within the clinical range
  - (Of those with completed measures) 15% children had total scores within the elevated range

- **TIME 2:**
  - 45% children had total scores within the clinical range
  - (Of those with completed measures) 10% children had total scores within the elevated range
Evaluation

How do you rate the overall quality of the programme you have experienced?

How effective was the teaching?

How helpful was the group discussion?

How helpful were the worksheets and exercises?

How helpful were the handouts?

Average score out of 10 (10 = very high, helpful or effective)

Satisfaction Ratings
Evaluation

To gain an understanding of the challenges of parenting children with relationship difficulties

To explore ways of building emotional connections with children whilst also providing support for behaviour

To explore the importance of looking after yourself and ways to do this

How well has the therapeutic programme met it's objectives?

Number of participants

- Fully achieved
- Partially achieved
- Not achieved
**Change in self-reported knowledge and understanding**

- **Rating of knowledge and understanding BEFORE the programme**
- **Rating of knowledge and understanding AFTER the programme**

**Change in self-reported knowledge and understanding**

**Rating of knowledge and understanding out of 10**

1. **Number of Participants**
2. **Self reported change (point difference between pre and post rating of knowledge and understanding)**
Conclusions and Learning Points

• Group-based interventions are feasible and acceptable for adopters to attend, and for services to run

• Group-based interventions, with the correct format, allow for high levels of peer validation and support

• Foundations for Attachment has been well-received with very positive evaluations collated

• Positive trends across all outcome measures on a small data set

• Potential for improvement in parent well-being, self-efficacy, understanding, child well-being and presenting behaviour

• Qualitative feedback suggests improvement in areas of parental confidence, family cohesiveness and use of PACE-based parenting strategies
Plans

• Continuing to contribute data to pilot project
• Service Research Projects
  • Qualitative study on the experience of adopters
• Special Guardianship Orders (SGO) families
• Developing universal offer for new adopters
• Consideration of follow up sessions on an individual or group facilitation basis