

***RESME COURSE CURRICULUM***

***Working at the borderline:***

***Improving inter-professional collaboration***

***Orientation day***

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## ***Introduction***

Welcome to this handbook. It has been designed to introduce you to the RESME course and support your orientation into the process. The In-service RESME course for practitioners working with young people at risk in residential care and mental health settings will be taking place in six countries across Europe. The course has been designed as a continuing education course. It will enable you to critically reflect on your work with this group of young people, to share your experiences through inter-disciplinary collaboration on the course and to learn from experiences in other countries.

## ***Rationale for the programme***

Although it is universally acknowledged that the family is the best place for a child's positive development, there are occasions when the child's care must be entrusted to residential settings. The European Council has lately considered the issue that two of the key professional orientations, child care and mental health treatment, are operating separately. Problems in cooperation and collaborative practice exist between child care practitioners and mental health practitioners. Yet the children and young people who come to the attention of mental health and residential child care services are likely to be drawn from the same population with the same issues. This course is designed to encourage inter-professional understanding and mutual learning.

This inter-professional continuing education course has been devised to help practitioners have a clear and helpful way to promote learning and inter-professional collaboration between residential settings and mental health settings. It also provides a unique platform to learn from other countries.

The modules are based on topics which emerged from an analysis of research carried out with child care and mental health practitioners in the six participating countries. The material in the modules will allow the participants to collect a portfolio of learning which they will be able to use to further enhance collaborative practice.

The programme consists of 3 modules and will last for 5 months. At the end of the course, a national seminar will be held which will look at how practice has developed across the course. A copy of all of the course module outlines is contained in Appendix One.

## ***About this handbook***

This is the orientation handbook and activities for the course and takes one day to complete. It consists of a series of activities which will introduce you to the course, its rationale, and the learning methods used on the course. It will also outline your timetable. All of the material you need for your orientation day is contained in this handbook.

The handbook has been divided into activities with clear guidance on what objectives should be met at the end of each activity.

### ***Orientation day: Introduction and methods***

This day provides an orientation to the course. It is important because it serves as the foundation to the course and allows participants to familiarise themselves with the overall aims of the course

The **aim** of the day is to enable participants to orientate themselves to the course, how it is structured and what is expected of you on the course.

The **objectives** of the day are

- To introduce participants to the rationale and structure of the course
- To introduce participants to the methodologies used in the course (e.g. reflective writing, critical appraisal, e-learning)
- To create opportunities for the participants to get to know each other
- To set up the learning sets which will be used throughout the course
- To allow participants to develop a 'personal profile' which will be used for the international aspect of the course

### **Programme for the day**

9.00 – 9.30:	Arrival, registration, ground rules and introductions
9.30 – 10.00:	Rationale for the course
10.00 – 10.15:	The teaching and learning methods
10.15 – 10.30:	Break
10.30 – 11.30:	Critical appraisal
11.30 – 12.00:	Reflective writing
12.00 – 12.15:	Learning sets
12.15 – 1.15:	Lunch
1.15 – 1.30:	Activity
1.30 – 2.00:	Using the online platform
2.00 – 2.45:	Developing and uploading personal profiles
2.45 – 3.00:	Break
3.00 – 3.45:	Identifying challenges and learning needs
3.45 – 4.30:	Pre-evaluation and next steps

## **Activity 1 : Arrival, registration and introductions**

**Time to complete the activity:** 30 minutes

**Objectives :** Participants will

- Feel comfortable in the training
- Get an opportunity to have some fun
- Be introduced to each other and their professional settings
- Go over the ground rules for the day

Your tutor will lead you through an introductory activity. The key point is to ENJOY this !

During this activity you will have your first opportunity to meet your fellow participants. You will also get to know your tutor/s and go over the timetable for the course.

### ***Ground rules for the face-to-face days***

- **Listen to each other carefully:** if you are unsure about a point that has been made by another person, ask them to clarify their point.
- **Confidentiality:** the day will be a safe place for participants to express their ideas, attitudes and knowledge and to try out new skills. The only exception to this will be where the welfare and safety of children and young people are concerned.
- **Give each other time to give opinions:**
- **Smoking:** should only take place in designated breaks and in designated areas.
- **Time-keeping:** sessions will begin and finish on time, as negotiated with the tutor/s.
- **Mobile phones :** should be switched off at all times when training is taking place, unless an alternative agreement has been reached with the tutor.
- **Anything else?**

**Tutor/s details**

Take a note of tutor / s details below.

*Name/s:*

*Organisational address:*

*Phone numbers:*

*Email addresses:*

If for any reason you cannot attend any of the face-to-face days or cannot complete the e-learning tasks, please let both your tutor and your workplace know.

## Timetable

Date	Title
16.1.14	Orientation (Handbook one)
17.1.14	International issues and framework for borderline practice (Module One: Handbook two)
16.1.14-28.2.14	International issues and framework for borderline practice (Module One: Handbook three)
27.2.14	Problems that practitioners face in everyday work: Approaches to practice (Module two: Handbook one)
3.3.14-20.4.14	Problems that practitioners face in everyday practice (Module Two: Handbooks two and four)
27.3.14	Problems that practitioners face in everyday work: Psychiatric and mental health problems (Module two: Handbook three)
24.4.14	Inter-professional issues and collaboration: Borderline collaboration (Module Three: Handbook one)
21.4.14-4.2.14	Inter-professional issues and collaboration (Module three: Handbook two)  Three day work shadowing placement (Module two: Handbook three)
22.5.14	Final synthesis, evaluation and preparation for National Seminar Day (Module Three: Handbook four)
Week ending 11.9.14	National Seminar Day

**The sections in red are face-to-face days. The sections in black are self study / e-learning /independent work periods. The dates for the face-to-face days and the blocks of time set aside for the self-study periods are given in the first column of the timetable**

## **Activity 2: Rationale and outline for the course**

**Time to complete the activity :** 30 minutes

**Objectives:** Participants will;

- Be introduced to the course and the reason why it came into existence
- Be introduced to the other countries who will be part of the course
- Be introduced to the outline of the course by going through the modules

Your tutor will give a short powerpoint presentation on how the course came to be developed. The tutor will also go over the module outlines (contained in Appendix One), course structure and timetable

The aim of this course is to promote inter-professional learning and collaboration between mental health professionals and residential child care professionals who are working on the borderline.

The objectives of the course are:

The objectives of the course are:

- To allow each group of professionals to explore the common nature of the children and young people with whom they work
- To provide opportunities to share knowledge about specific aspects in the lives of vulnerable children and young people with whom they work
- To provide practical experience of each other's working structures and environments
- To encourage reflection on the application of learning to practice when working at the borderline
- To provide opportunities to learn from each other's experiences
- To produce a research and development report for sharing at the National Seminar



### Activity 3: The learning methods

**Time to complete the activity:** 15 minutes

**Objectives:** Participants will:

- Be introduced to the teaching and learning methods used during the course
- Have the opportunity to ask questions about how the course will operate

#### Learning and teaching methods

The course will use a blended learning approach. This follows the best principles of adult learning and also helps us to encourage learning and collaboration with each other. Here is an outline of the methods to be used:

- a. Face-to-face days: During the course you will have a designated tutor. Most of the time, the tutor will act as a facilitator for the learning activities. Occasionally, however, some of the activities will require a small amount of direct teaching by the tutor. This is tutor input.
- b. Groupwork: For most of the course, you will be carrying out activities in groups. The course is designed to encourage cross-fertilisation of knowledge and practice across residential practitioners and mental health practitioners, and across countries. To this end, there will be three different types of groups. These are (i) professional learning sets where you will work in a small group with your fellow practitioners (ii) inter-professional learning sets where you will work in a small group with practitioners from another setting (iii) full group where you will work as a large group from mixed professional backgrounds. Your tutor will allocate you to professional learning sets and inter-professional learning sets during the course of your induction day.
- c. Pairs work: You will be allocated an inter-professional partner from the group. Your partner will be from another professional group. As well as working on the face-to-face days with your partner, you will also be given an opportunity to work alongside them in their organisation and they will have the opportunity to work alongside you in your agency.
- d. Self study / E-learning: The course places an expectation on participants that they will complete a range of work on their own. The individual E-learning work will be supported by a participant handbook and clear guidance will be given on what is required. Some of the individual work will be related to looking at the material generated by colleagues in other countries. This will be available on an online platform. Some of the individual work will be guided self-study. Another part of the individual work will be related to your *Research and Development Report*. Once again, clear guidance will be given as to what this means.

- e. International work: The course is designed to help us not only to improve understanding and collaboration within each country, but also to encourage collaborative learning across the countries involved in the project. The international work will involve participants looking at the work produced by their international counterparts. It will also involve local participants in producing material which will be placed on the online platform. Guidance on work to produced and accessed for each of the modules will be given during the course delivery. Your tutor will now give the group an opportunity to ask questions about the learning methods and the practical ways in which the course will operate.
- f. Placement: each participant will have a 3 day placement sometime between 21.4.14 and 2.6.14. For this, you will have the opportunity to work shadow someone from a different profession. The actual dates will be negotiated between you and your inter-professional partner.

#### **Activity 4: Critical appraisal**

**Time to complete the activity:** 60 minutes

**Objectives:** Participants will:

- Be introduced to techniques for critical appraisal and one tool which will be used for this during the course

#### **Critical appraisal**

‘Critical appraisal is the process of carefully and systematically examining research to judge its trustworthiness, and its value and relevance in a particular context’ (Burls 2009)

Although the process of critical appraisal has been developed more strongly in health care, it is important to use this approach to social care as well. More often we are being asked to implement evidence based practice. But how do we decide what evidence is best?

In Appendix two, there is a copy of a critical appraisal tool. Using this tool, read the paper entitled ‘Conceptualizing collaboration between children's services and child and adolescent psychiatry: A bottom--up process based on a qualitative needs assessment among the professionals’ by Janssens et al, which is contained in Appendix 3. Be prepared to discuss your thoughts in the large group.

Burls, A. (2009). What is critical appraisal? London, Hayward Group.

[www.whatisseries.co.uk/whatis/pdfs/What\\_is\\_crit\\_appr.pdf](http://www.whatisseries.co.uk/whatis/pdfs/What_is_crit_appr.pdf) Accessed June 2013

## **Activity 5: Reflective writing**

**Time to complete the activity:** 30 minutes

**Objectives:** Participants will:

- Examine the importance of reflective writing, explore one model of reflective writing and be introduced to the reflective logs that will be used throughout the course
- Examine the Model for Describing Best Multi-Professional Practice and the importance of applying this to case studies in practice as a means of inter-professional learning

### **Reflecting on practice**

Reflection on practice is an important part of maintaining good professional standards. It encourages you to examine the reasons why you work in the way that you do, what informs your work, and how to improve practice in the future. In this course you will be asked to write reflective accounts based on what you are learning and also based on the discussions you are having with inter-professional and international participants in the course.

There are many models of reflective writing but one of the best known is the Gibb's model. The model is represented in the diagram over the page:

## The reflective writing cycle (Gibbs 1988)



Gibbs G (1988) *Learning by Doing: A guide to teaching and learning methods*. Further Education Unit. Oxford Polytechnic: Oxford.

Working individually, write a short reflective account of a recent situation you had to deal with. Use Gibb's model as outlined above. The situation should be one where a child or young person was exhibiting some kind of behaviour which concerned you. Once you have completed this, you will work in an inter-professional pair. Exchange your accounts with each other. Read your respective accounts and then discuss if there are any aspects of the account and practice that you don't understand or are unclear about.

**Description**

**Feelings**

**Evaluation**

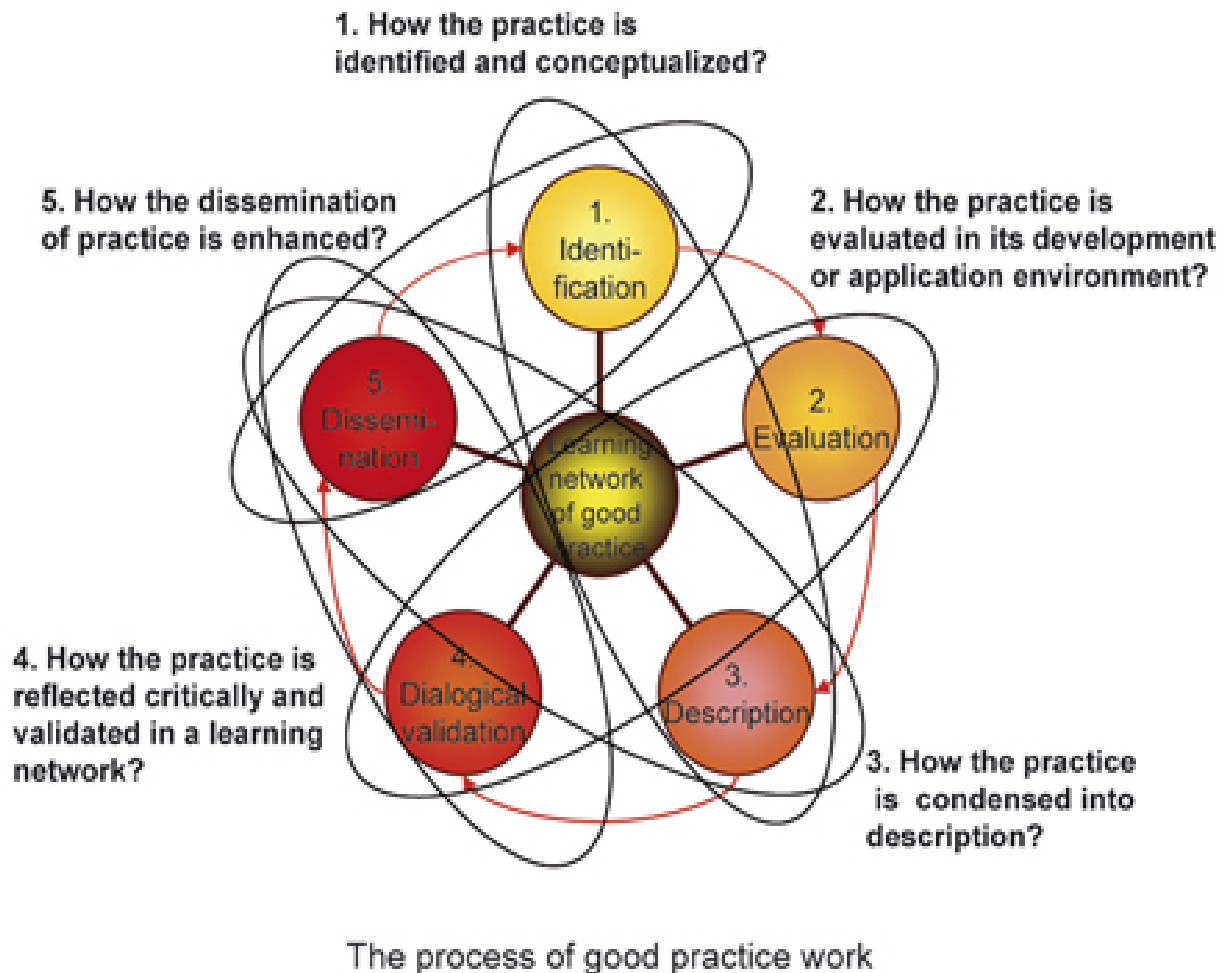
**Analysis**

**Conclusion**

**Action Plan**

## A model for describing best multi-professional practice

This model was devised by the National Institute for Health and Welfare in Finland.



We will be using this model later in the course to create a model of good inter-professional practice in each country that will be shared with the other countries. This will be highlighted when it comes up in the course.

### Activity 6: Learning sets

**Time to complete the activity:** 15 minutes

**Objectives:** Participants will:

- Be introduced to the concept of learning sets and how these will work
- Be allocated to their learning sets for the course

Learning sets are the small groups within which the bulk of your groupwork will take place. There are two kinds of learning sets. One is your professional learning set. While you are in this set, you will be working with 2-3 fellow professionals from the same type of setting (e.g. child care or mental health). The second learning set will be your inter-professional learning set. This will comprise 2 practitioners from residential child care and 2 practitioners from mental health.

Your tutor will now have some discussion within the large group and allocate you to your 2 learning sets. You should take a note of the names and settings of your fellow members as you will be working with them throughout the course.

### **Activity 7 : Warm up after lunch**

**Time to complete the activity:** 15 minutes

**Objectives :** Participants will

- Feel comfortable in the training
- Get an opportunity to have some fun and waken up
- Reflect briefly on the morning and be introduced to the afternoon session

Your tutor will lead you through a warm up activity

### **Activity 8: Using the online platform**

**Time to complete the activity:** 30 minutes

**Objectives:** Participants will:

- Learn how to use the online platform for international work
- Be given the opportunity to try this and to ask questions

The online platform to be used for the course is OPTIMA



OPTIMA allows a workspace to be created where participants both nationally and internationally can share each other's work. Your tutor will now give you a short tutorial on OPTIMA and you will be given the chance to use this today.

### **Activity 9: Developing and uploading personal profiles**

**Time to complete the activity:** 45 minutes

**Objectives :** Participants will

- Discuss and develop a format for their personal profile which will be uploaded
- Draw up their individual personal profiles
- Upload these onto the online platform

Your personal profile will be important so that all of the participants on the course will get a chance to become aware of each other's background, settings and experiences.

The profiles will be placed on the online platform and you will be expected to read all of the profiles over the coming days. Given that this is the case, you will discuss a format for the personal profile within your group. Once you have decided on the personal profile format (perhaps a simple template with headings) you will then use this to draw up your own personal profile. You will then upload your profile onto the online platform today.

Your discussion should take into account issues like confidentiality because these profiles will be within a public area !

You should keep a copy of your personal profile for your portfolio, which your tutor will be discussing on your next face-to-face day.

## Activity 10: Challenges and learning needs

**Time to complete the activity:** 45 minutes

**Objectives :** Participants will

- Discuss the promoters and barriers to their participation and completion of the course
- Examine Covey's idea of 'circle of influence and circle of concern' as a means of analysing how to develop an effective plan to meet challenges and learning needs
- Draw up their individual plan for overcoming barriers to course participation

The course recognises that all of the participants are practitioners with jobs, as well as being learners on this course. As such you will have a range of competing demands.

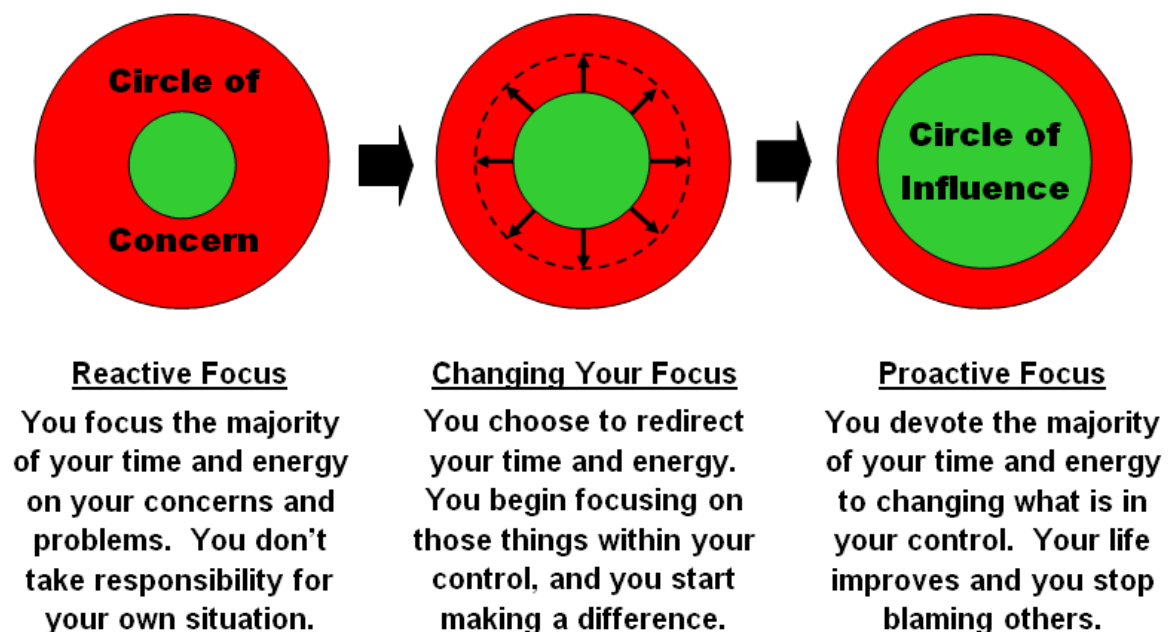
In your professional learning sets, discuss the promoters and barriers to your completion of this course.

Once you have done this your tutor will give a short input on Covey's ideas of the *circle of influence* and the *circle of concern*. This is one model which helps you to focus on how to look at your own approach to managing the different priorities in your life. A copy of this model is given overleaf.

In pairs with someone from another professional group, discuss the types of issues in work and personal life that have to be accounted for in finding the time to complete the course. Then draw up a personal plan to meet your challenges and learning needs, using the template in Appendix 4.

## Simple Version of Stephen Covey's Model of Proactive Management

### Adopting a Proactive Focus



Covey, S. (2004) *The Seven Habits of Highly Effective People*. New York; Simon and Schuster.

### **Activity 11: Next steps and pre-evaluation**

**Time to complete the activity:** 45 minutes

**Objectives :** Participants will

- Be given the opportunity to ask any final questions about their timetable and contacts for the course and discuss any issues arising
- Complete the pre-evaluation form over the page to provide feedback on how this day has gone
- Have confirmation from the tutor/s about what the next steps will be

The tutor will now ask the group to think about the day and what they have learned about the course. Some discussion will be encouraged about the questions. The tutor will then discuss the pre-evaluation process and ask each participant to fill out the pre-evaluation form overleaf. When each participant has filled in the form, the participants will be asked to discuss any particular issues that are arising from their forms.

Finally the tutor will discuss the format for the next face-to-face day, looking at roles and services, and the framework for practice for each of the sets of practitioners on the course

**Pre-course evaluation form**

**Can you please provide some comments on the following:**

<p><b>the format and material for the orientation day</b></p>	
<p><b>the methods that will be used (e-learning, learning sets, pairs work, critical appraisal etc)</b></p>	
<p><b>What kind of tutor support would be most helpful to you throughout the course?</b></p>	
<p><b>How adequate was the venue and arrangements for the orientation day?</b></p>	

<p>Have you any questions or concerns about the content and approach of the course as explained to you today?</p>	
<p>Have you developed a clear plan of your challenges and learning needs, and how to meet these during the course?</p>	

## APPENDIX ONE: MODULE OUTLINES

### ***Module One: International issues and frameworks for borderline practice***

This module provides the opportunity for the professionals involved in borderline practice to explain to each other what they do and how their services are structured. It also provides the opportunity to develop an international perspective on borderline practice. The **aim** of the module is to explore the structures, roles, ethical codes and philosophy underpinning approach to practice with young people

The **objectives** of the module are

- To learn about global and European perspectives in relation to mental health and residential child care
- To explore the policy and legal underpinnings of practice within each of the professional areas

- To explore the codes of practice which guide work in each of the professional areas
- To ensure that participants are familiarised with some of the common diagnoses in mental health services
- To examine the critiques of the medical model
- To ensure that participants are familiarised with the historic development of group care
- To outline the key ideas from social pedagogy and child and youth care (CYC)

### ***Module Two: Problems that practitioners face in everyday work***

This module provides allows professionals involved in borderline practice to explore some of the key issues and practices which are common to work on the borderline. It will also encourage participants to develop case work by focussing on actual cases in real life.

The **aim** of the module is to extend and deepen the knowledge of work practices which help professionals to deal with the problems they face in everyday work and to learn from each other and from other countries.

The **objectives** of the module are

- To explore contextual issues which affect practice (i.e. images of childhood, working with families, culturally sensitive practice)
- To reflect on some of the key problems which affect the young people with whom we work (i.e. trauma, loss, separation, substance misuse, self-harm)
- To develop case work examples from real practice
- To further identify the challenges and benefits of multi-professional collaboration on the borderline



### ***Module Three: Inter-professional issues and collaboration***

This module provides the opportunity for the professionals involved in borderline practice to examine some of the organisational issues affecting collaboration and to develop strategies to improve collaborative practice.

The **aim** of the module is to understand, undertake and promote the best collaborative practice.

The **objectives** of the module are

- To explore some of the theories of organisations and organisational change
- To critically appraise their own organisation and its capacity for change
- To experience work in another setting on the borderline
- To identify an area for change in inter-professional practice which they can implement in their own workplace and compile a research and development report on this area
- To prepare for the national seminar day during which research and a European training needs analysis will be presented.

## **APPENDIX TWO**

### **Critical appraisal tool**

This critical appraisal tool is adapted from one developed by Long AF, Godfrey M, Randall T, Brettle AJ and Grant MJ (2002) *Developing Evidence Based Social Care Policy and Practice*. Leeds: Nuffield Institute for Health.

#### *(1) INTRODUCTION*

If the paper has an introduction or an abstract, what are the aims of this paper ?

#### *(2) CONTEXT*

What type of paper is this? Is it a research paper, a summary, a report, a review or something else?

What geographical and health/care setting is the paper addressing? Over what time period is the paper addressed? How recently was the paper published?

#### *(3) ANALYSIS*

Give a brief outline of the summary or recommendations of the paper. What are its key aims? What data collection methods or sources of information were used in the paper? How wide or selective were the sources? How well is the analysis laid out? Are arguments clear? Is there clear evidence for any statements made? Are recommendations or conclusions valid and reliable given the information collection?

If it is a research paper, is the research methods adequately described? How were the data analysed? How adequate is the description of the data analysis? Are the findings interpreted within the context of other studies and theory? What was the researcher's role? Are the researcher's own position, assumptions and possible biases outlined?

What are your own views about the paper? What have you learned and what could be clearer? Have you any unanswered questions as a result of reading the paper? What could have been done better?

#### *(4) POLICY AND PRACTICE IMPLICATIONS*

Implications: To what setting are the paper's findings generalisable? To what population are the paper's findings generalisable? Is the conclusion justified given

the analysis and the information gathered? What are the implications for policy? What are the implications for service practice?

## **APPENDIX THREE**

Janssens, A., Peremans, L. and Deboutte. D. (2010) *Conceptualizing collaboration between children's services and child and adolescent psychiatry: A bottom-up process based on a qualitative needs assessment among the professionals*. Clin Child Psychol Psychiatry, 15(2), 251-266.

### **Abstract**

Little is known about the need of professionals of children's services and child and adolescent psychiatry to collaborate. This study aimed to explore the perception of practitioners of both services with regard to a future collaborative partnership improving the wellbeing of children in children's services. Eight focus groups were performed and analysed, following the principles of the Grounded Theory. The focus groups revealed that the professionals agree considerably concerning the outlines of the collaboration. They agree upon the primary goal of the partnership, their expected role and tasks. In addition, the partnership should develop in an atmosphere of mutual respect and with the intention to provide the best care for the child. The results of the focus groups are discussed in consideration of a future implementation of interventions on developing best practices at the intersection of children's services and child and adolescent psychiatry.

### **Keywords**

child and adolescent psychiatry, children's services, focus groups, inter-agency working, needs assessment

### **Introduction**

Although estimates may vary, there appears to be a high prevalence of mental health problems among children and adolescents in children's services. In addition, the treatment needs of these children and adolescents with mental health problems are poorly met (Burns et al., 1995, 2004; Nicholas, Roberts, & Wurr, 2003; Stiffman et al., 2000). Many researchers suggest that interagency working is a key solution in addressing the complex needs of these children (Arcelus, Bellerby, & Vostanis, 1999; Lyons & Rogers, 2004; Stanley, 2005). The promising theoretical advantages of this service model of mental health provision for children in children's services have been well established (Knitzer & Yelton, 1990). Factors supporting the call for joint working, as resumed by Darlington, Feeney, and Rixon (2005b), include the

bringing together of knowledge, skills and values of different professions and agencies to generate creative solutions for these families, who would otherwise be beyond the scope of any person or agency (Costongs & Springett, 1997; Mattessich, Murray-Close, & Monsey, 2004), improved cost effectiveness (Johnson, Wistow, Schulz, & Hardy, 2003), faster access to services (Cottrell, Lucey, Porter, & Walker, 2000), reduced anxiety for workers (Hetherington, Baistow, Katz, Mesie, & Trowell, 2002), greater continuity of care and more holistic services (Williamson, 2001). These benefits have strengthened policymakers to promote, and sometimes even mandate, the implementation of a partnership between children's services and child and adolescent psychiatry. However, there is little evidence that supports the effectiveness of these multiagency collaborations in meeting the needs of these children, and the few evaluations that have been carried out were methodologically poor (Cameron & Lart, 2003; Sloper, 2004).

How come, given the wealth of documents highlighting the importance of multiagency collaboration and government policy recommendations, effective collaboration between children's services and child mental health services remains elusive? There is a vast amount of literature that reports on barriers and points of breakdown in the collaborative relationship (Bruner, Kunesh, & Knuth, 1992; Darlington, Feeney, & Rixon, 2004, 2005a; Hallett & Birchall, 1992; Johnson et al., 2003; Quinn & Cumblad, 1994; Secker & Hill, 2001). Stevenson (1989) noted five major barriers to collaboration: Structures and systems (expectations about accountability, supervision and responsibility for decision making will be different across agencies with different roles, histories, cultures, powers and priorities), communication (dis-agreements concerning sharing information and the content and value of communicating), status and perceived power (differences between agencies can lead to real and felt power differentials within the partnership), professional and organizational priorities and the extent to which collaboration is perceived as mutually beneficial. More recent studies have added little to the existing knowledge on factors that are essential to ensure a successful collaboration, questioning the evolution in the approach of collaborative working in practice (Brandon, Howe, Dagley, Salter, & Warren, 2006; Darlington et al., 2004; Friedman et al., 2007; Johnson, 2001; Morrison, 1996; Salmon, 2004).

Mostly, the collaborative processes have been top-down responses to the problem with governments making partnerships mandatory. Despite the emphasis on evidence-based policy making and with the ideological environment that is uncritically procollaboration (Dowling, Powell, & Glendinning, 2004), questioning the need of joint working is appropriate. Furthermore, a top-down approach might not be the best way to deal with this since partnerships will only be successful if the professionals concerned support it.

The needs assessment presented in this article was conducted as part of a large mixed-method research project on developing best practices at the intersection of children's services and child and adolescent psychiatry. The project follows a bottom-up approach and begins with a needs assessment among practitioners of children's services and child and adolescent psychiatry. The aim of this study was to examine to what extent practitioners experience the need to make an appeal to external expertise, whether they consider interagency collaboration between children's services and child and adolescent psychiatry as a possible model of

mental health provision for children in children's services (as suggested by many researchers), and if so, how they would organise this collaboration.

## **Method and Design**

The needs assessment described in this article is part of a larger mixed-method research project aiming to improve the mental health of children in children's services. During the first phase of the project a needs assessment, using focus groups, was conducted among the professionals of children's services and child and adolescent psychiatry. Simultaneously, the Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) was administered to all children of the participating children's services to assess their mental health status. The second phase constituted the implementation of the interventions, based on the results of the focus groups. The SDQ, administered again after the implementation, and a satisfaction questionnaire for the practitioners of children's services, were used to evaluate the project.

The subject under study is rather complex and existing knowledge inadequate. The method of focus groups is particularly useful for exploring people's knowledge and experiences as it encourages group interaction (Kitzinger, 1994, 1995). In addition, the opportunity to be involved in a decision-making process can be empowering for participants (Denning & Verschelden, 1993; Race, Hotch, & Parker, 1994). This study being part of a larger action research could benefit from this advantage.

In total, 30 professionals of children's services and 26 of child and adolescent psychiatry were involved in the focus groups. The focus groups of children's services were stratified by job position and type of placement (see Table 2). This resulted in homogeneous groups with respect to job responsibilities as to create an atmosphere where participants feel comfortable and which allows them to speak freely. The results of the analyses were presented to the representatives of all services involved in the study and to representatives of children's services and child and adolescent psychiatric centres of other provinces.

## **Participants and sampling**

Sixteen children's services and one child and adolescent psychiatric centre in the region of Antwerp (Belgium) are included in the project. A purposive sample of 16 children's services was selected to represent the region's demographic characteristics as well as the five different types of placement concerned. As there is only one child and adolescent psychiatric centre in the region, this was the unique one represented in the study.

All personnel of the participating services were informed about the project by a letter of the researcher, explaining the purpose of the project and the rationale for their involvement. In addition, the respective representatives of the participating services announced the focus group sessions on an internal meeting. Participation was voluntary and all who volunteered were invited until a postulated maximum inclusion was reached. The recommended number of participants per group is 6 to 10 (Powell & Single, 1996). We allowed 10 inclusions, considering annulations. Assurances were given that individual participants' identity would not be revealed. Table 1 and 2 give an overview of the main characteristics of the participants for each focus group.

**Table 1. Main characteristics of the participants from the child and adolescents psychiatric centre**

<b>Child and Adolescent Psychiatric centre (CAP) 3</b>		<b>Group 1</b>	<b>Group 2</b>	<b>Group 3</b>
Mean age		40,2	38,3	33,2
Mean years of experience	16	10,7	7,7	
Gender (Male/Female)		2/8	2/7	2/5
Level of education				
Psychiatrist (Master degree+ 5yrs specialisation)		3	3	1
Master degree (5yrs)		4	6	4
Bachelor degree (3yrs)		3	0	2
Observation marks from observer / moderator				
Participation	Good	Excellent	Excellent	
Atmosphere	Good	Good	Good	
Arousal		Moderate	Little	None
Influences/disturbances		2 phone calls 1 person 30' late		

**Table 2. Main characteristics of the participants from the children's services**

<b>Children's services (CS) Group 5</b>		<b>Group 1</b>	<b>Group 2</b>	<b>Group 3</b>	<b>Group 4</b>
Mean age	36,4	34,3	39,3	29	41,4
Mean years of experience	7,2	8	9,1	6	15
Gender (Male/Female)	1/9	2/4	3/0	1/3	5/2
<b>Level of education</b>					
Master degree (5yrs)	2	1	1	2	5

Bachelor degree (3yrs)	6	4	2	2	2
Vocational training (1yr)	2	1	0	0	0
Function Guidance	Family worker	Family/Social	Social/Management	Guidance	

### Type of agency

Guided independent living	0	2	0	1	
Home based care	6	1	0	0	1
Day care centre	0	2	0	1	1
Residential care	0	3	1	3	3
Foster care	4	0	0	0	1

### Observation marks from observer / moderator

Participation	Good	Excellent	Excellent	Good	Excellent
Atmosphere	Moderate	Good	Excellent	Good	Excellent/ good

Arousal                      Much Little None None Much

Influences/disturbances    1 dominant    3 participants    2 participants    participant excused

### Data collection

The same trained moderator, an experienced nurse who was no member of the research team, and observer (first author) conducted all focus groups. The moderator presented consent forms to the participants and made sure they had read and understood them before signing. Participants were reminded that the session would be audiotaped and that a second person would be taking notes throughout the discussion. During the discussion the observer was seated away from the actual group members. Participants were informed about the basic rules of focus groups to facilitate an environment, conducive to free and open discussion by all group members (Krueger, 1998). A flexible topic guide containing four prepared open-ended questions was at the moderator's disposal to maintain and guide the discussion in the groups (see Table 3 and Table 4).

The focus groups with practitioners from the child and adolescent psychiatric centre took off with an opening question concerning the problems encountered during the guidance of their clients. This question was experienced by the participants as vague and confusing. Although this brought along interesting information, it was necessary for the moderator to redirect the conversation using the back-up introductory question (see Table 4). This question was used throughout the following focus groups.

### Data analysis

Focus groups were audiotaped and transcribed verbatim. The moderator and observer held a short debriefing after each session verifying the common perceptions and ideas. Summaries of these debriefings were added to the transcripts, together with the observer's notes of the nonverbal communication and interaction between the participants.

The collected data, transcripts and field notes were analysed using a Grounded Theory approach (Strauss & Corbin, 1990). The data are fragmented into text units representing a discrete idea (a sentence or paragraph) and coded. For reliability purposes and to ensure that all possible meanings were captured accurately, two different coders (AJ and LP) executed the whole analysis process. The results of the open coding of both coders are being compared and final codes are attributed. In Grounded Theory, the analysis occurs simultaneously and in constant comparison with the data collection until saturation is achieved. Focus groups for children's services and child and adolescent psychiatry were analysed separately. During the process of constant comparison, a third focus group was set up in child and adolescent psychiatry as no saturation of the data was obtained. Data collection within children's services was completed after five focus groups, when category saturation was reached and no new codes or categories could be derived from the data.

After the open coding, the data were reduced to a set of 637 items for children's services and 544 items for child and adolescent psychiatry. These items were compared and grouped by the coders resulting in respectively 72 and 48 categories that accurately described the perceptions of the practitioners of children's services and child and adolescent psychiatry. Identifying commonalities between these classifications led to the development of a selected number of core themes, representing the main ideas. Themes and categories were then linked together to form a coherent model.

After the analyses, results were presented to the assembled representatives of all participating services. The same presentation was organized in the remaining provinces in Flanders, to validate the results. The authenticity of the themes was confirmed, with this exception: One province deemed the theme "getting to know each other" inapplicable to themselves. They judged to sufficiently know the service provision and working philosophy of the other service. The theme was not removed as the other validation groups did confirm the lack of knowledge among their practitioners. No further substantial alterations were made by the participants during the presentations.

Table 3: Focus group topic guide – children's services

1. Dealing with children in children's services is not always easy. With your experience in this field, which problems do you encounter while working with these youngsters?
2. How do you deal with these problems?
3. With which of these, or any other problems, could you make good use of outside assistance?



And how is it done? What is the procedure?

4. For which of these problems could the assistance come from child and adolescent psychiatry? And to what extent do you already appeal to child and adolescent psychiatry at this moment?
5. How do you see the collaboration between child and adolescent psychiatry and children's services? What specific expectations do you have when appealing to the assistance of child and adolescent psychiatry? How could children's services contribute to the collaboration?

Table 4: Focus group topic guide – child and adolescent psychiatry

1. Which problems do you encounter during the coaching/guiding of the children and adolescents in child and adolescent psychiatry?
2. Back-up question: who are the referral persons or institutions of the children in child and adolescent psychiatry? Where do they come from and where are they referred to when leaving child and adolescent psychiatry?
3. With which of these problems could outside assistance be a solution?
4. In which way could children's services offer assistance to you or your clients when dealing with these or other problems? And to what extent do you already appeal to children's services at this moment?
5. How do you see the collaboration between child and adolescent psychiatry and children's services? What specific expectations do you have when appealing to the assistance of children's services? How could child and adolescent psychiatry contribute to the collaboration?

## Results

The analysis of the focus groups in children's services and child and adolescent psychiatry showed a considerable resemblance. The content being somewhat different, four core themes emerged from both analyses: "Themselves", "the other", "collaboration", and "context". The management, internal expertise, know-how and target population of the own service (respectively children's services or child and adolescent psychiatry) constituted a first theme. Similar statements were made about the other service: How they perceived and experienced the other group's service provision, management, know-how and working philosophy. Statements about current and possible future collaboration were grouped in a third theme. The fourth theme refers to the context in which current collaboration takes place and contains statements concerning issues of higher level structures and policies.

Collaboration was not the most prominent topic in the discussions. This reflects the actual state within the field: There is no structural collaboration between the two sectors and when it occurs it is irregular and case-specific. The focus groups revealed a considerable amount of barriers and bottlenecks, similar to those reported in other studies as summarised in the introduction. They will be mentioned whenever

the covering theme is discussed. The results, together with verbatim extracts of the participants' contributions, are outlined in the following paragraphs. They are presented as to reflect the thread of the focus groups.

#### Reported problems encountered while working with their clients

All practitioners of children's services reported being confronted with a wide range of psychiatric problems among their clients. Most frequently mentioned difficulties were: Tantrums, auto-mutilation, children skipping school and other school-related problems, suicidal attempts, extreme violent behaviour, child maltreatment and abuse, depression, ADHD, autism, and eating disorders.

*We are confronted with a wide range of problems: Drugs, aggression, sexual cross-border behaviour. (Somebody fills in): Anorexia, ADHD, skipping school, unsatisfactory school performance, behavioural disturbances, lying and stealing, extreme acting-out behaviour, suicidal behaviour . . . (CS, group 1)*

All supplied that they usually felt apt to cope with the emotional and behavioural problems of the children and adolescents. For all participants, direct colleagues and agency staff were cited as the primary sources of advice:

*We prefer first to look within our own service, we have bachelor and master level degrees in psychology and criminology on the team. We try to ask people in our own service for as long as possible in order to keep our youngsters here. (CS, group 4)*

Practitioners of child and adolescent psychiatry had difficulties responding to the opening question. The introduction of the back-up question made it clearer to the participants. The main problem was linked to the topic of referrals. They all agreed the primary problem is getting their clients referred to welfare services, after psychiatric intervention. Especially psychiatrists endorsed that, too often, children stayed longer than necessary in the psychiatric centre. They argued that a child with a psychiatric problem is not automatically better off in a child and adolescent psychiatric centre:

*I'm not willing to keep a child who has had anorexia, and is doing much better now, because we cannot find another service that wants to admit her. Some people don't seem to understand that an admission into a psychiatric centre is not always healthy and helpful for a child. (CAP, group 2)*

*The long waiting lists of children's services were mentioned as an important cause for this problem. In addition, many participants said to feel cornered as children's services refuse to admit children with psychiatric problems: "It's not always a question of place shortages, sometimes there is a place available but the issue is not accepted" (CAP, group 3).*

#### **To collaborate or not to collaborate?**

Most of the practitioners of children's services openly demanded collaboration with child and adolescent psychiatry to meet their needs:

*"Sometimes we notice that the nature of problems are such that we need extra help, from outside. That's when we need to get into contact with child and adolescent psychiatry" (CS, group 5).*

All practitioners rejected the idea of the foundation of a new service integrating both services. As participants touched upon the subject of an integrated service, the moderator presented the idea to the whole group to record their reaction. Although most of them wanted the collaboration to be structurally embedded in the operation of both services, they all explicitly mentioned it should not be a continuous collaboration. Only one participant declined all organized collaboration, and said the process would arise and be dealt with along the way when necessary. All other participants wanted to be able to appeal on the professionals of child and adolescent psychiatry, whenever they fail in their duty towards their clients:

*“You have those kinds of situations, where you think: I would like to talk to a psychiatrist because I see some child’s behaviour that worries me. And then I think consultancy would be helpful” (CS, group 1).*

They clearly added that the collaboration should be mutual. They indicated they are trained and experienced in working with children with difficulties living in deprived situations. They want to share this knowledge, as they experience a shortage on this level when working with professionals from child and adolescent psychiatry.

All participants of child and adolescent psychiatry first mentioned how they want to support professionals of children’s services. They indicated that they have felt the needs of children’s services while working with children under their care. They added that these needs could only be met under certain conditions:

*“Recently we received active signals from people in children’s services requesting collaboration. These signals become more concrete, lately, by them calling on our expertise, and if possible we comply with the request” (CAP, group 3).*

Only after directly posing the question of whether the collaboration could be reciprocal, they started thinking what professionals of children’s services could offer them. One professional with previous experiences in children’s services at first simply proposed how child and adolescent psychiatry could meet the needs of children’s services. Only after the moderator’s intervention this participant realized that collaboration could be reciprocal. Later on, many of the participants joined him and admitted to lack knowledge on the service provision of welfare in general. Children’s services could provide them with the correct and necessary information.

### **Shaping the collaboration: Unknown, unloved – the self-fulfilling prophecy as a reality**

A mutual partnership based on respect, centred on the child. The focus groups revealed how these professionals insist upon their autonomy and professional skills and demand to be respected. Several professionals of children’s services revealed to feel underestimated in their role and their competences and all asked to be treated as equal partners. Moreover, many of them mentioned to be generally undervalued, by health care services as well as by the responsible governments:

*We are looking for a partnership where everyone’s expertise is valued and everyone can bring in their expertise. But until now I have only heard of one-way traffic of know-how, yet, we can also offer something. Although I often feel that our know-how is not taken seriously. This has to change. (CS, group 3)*

Many professionals of child and adolescent psychiatry often felt “dumped on” by children’s services. Clients with multiple and complex needs appeared to be passed around services and finally were referred to child and adolescent psychiatry as the last possible resort. By members of both sectors, collaboration is seen as a partnership, supporting each other in their job, tasks and assignments and offering a part of their own expertise and know-how:

*These are children with cross-discipline problems that need support and care from both sides (referring to child and adolescent psychiatry and children’s services). Somebody fills in and we should not stay in our corner, but back up for each other, them for us and we for them. (CAP, group 1)*

*We want to admit children with severe psychiatric problems, under certain conditions. We want you (member of the child and adolescent psychiatric centre) to participate as well. As long as we take on the child’s care, you stand next to us, alongside the team, that we can call upon you, even on a Friday evening, when things get out of hand. (CS, group 5)*

All of the participants endorsed how both services pursue the same goal: The welfare of the child. Many professionals saw this partnership as the ultimate solution to realize the necessary care and aid for children with complex needs. For the majority of the participants, this partnership had to be (well) organized, certainly not as a seamless cross-agency way of working.

### **Roles and boundaries.**

Professionals of both services admitted, but at the same time accused the other party of having insufficient and sometimes incorrect knowledge of the job responsibilities, working and organization of the service of the other. The theme “getting to know each other” was apparent in all of the focus groups. It appeared that all participants felt the need to become better informed about the tasks, assignments, strengths and restrictions of the other service: “Knowing how they work, look at things, what they do. I think I still have a lot to learn there” (CAP, group 3). Nevertheless, during the focus groups participants of both services clearly stated the role they wanted to take on in the partnership, as well as their expectations towards the other service. Although they held incorrect assumptions concerning job responsibilities of the other service, the respective task assignments corresponded well. The next two paragraphs will examine this matter further.

**Children’s services as the case manager.** Practitioners of children’s services found they had to offer child and adolescent psychiatry a more complete image of the provision of services within children’s services and the social sector. This was meant to facilitate the development of a suitable care trajectory for a child leaving child and adolescent psychiatry. They mentioned that children were too often referred to a service that could not offer the requested care. Moreover, they felt responsible for the children and adolescents they themselves referred to child and adolescent psychiatry. They preferred to remain the primary care service for the child:

*We want to offer these children continuity. We try to keep them as long as possible, using the means within the team. And if an admission into a psychiatric centre is essential, we want to be kept informed. We are the ones that have to go on with this youngster. (CS, group 2)*

Practitioners of child and adolescent psychiatry on the other hand said to be dependent of children's services to continue the care for a certain client. They explained that a child and adolescent psychiatric centre cannot become the permanent allocation for a child. Besides, they mentioned, practitioners of children's services had a more complete overview of the social map and were better placed to organize and co-ordinate a child's care process.

**Child and adolescent psychiatry as the expert.** In most of the cases, professionals of children's services expected the psychiatric professionals to put their expertise at disposal, to strengthen their own competences to be able to fulfil their assignment as good as possible:

*We want to call on the aid of child and adolescent psychiatry when we are unable to deal with the situation or don't know what to do anymore. But we want to keep the child under our care as long as possible. We need child and adolescent psychiatry to support us in this. (CS, group 3)*

Professionals of child and adolescent psychiatry felt expert in the disruption of the development and of the functioning of children and adolescents, in the treatment and care of these children and their context. They were more than willing to meet the needs of children's services:

*We explain them how we approach eating disorders. We explain how they can deal with this in their residential homes, we give them alternatives as well. So you get a more consultative role. (CAP, group 1)*

Within a possible collaborative relation with children's services, they described their function as providing children's services with advice and support concerning psychiatric related topics and treatment of children and adolescents with psychiatric problems. They attributed themselves a supportive role.

### **Direct collaboration.**

Participants of both sectors repeatedly and explicitly asked for direct collaboration and direct contact. Many of the participants suggested this as a solution for numerous problems and barriers discussed throughout the focus groups. They explained that it would enable people to get to know each other and the working environment and that it would facilitate communication and information exchange. Some participants reported that they saw it as the only successful strategy to clear out roles and expectations at the beginning of a partnership. Different participants referred to the direct communication between professionals to avoid incorrect referrals, develop a common language, and stimulate mutual respect.

Several participants of children's services asked for onsite consultation. Often, they said, they are concerned about the mental health status of a child or adolescent under their care. The presence of a professional of a child and adolescent

psychiatric centre could help them addressing their questions, doubts and concerns. Everybody agreed that sometimes they felt uncertain and needed an external expert opinion when taking important decisions: Is the home situation secure enough to leave children with their parents, should this child still have contact with his or her parent(s)? Mostly management, personal and group leaders asked to share the responsibility in the decision-making process (out-of-home-placement, reporting on child abuse or child maltreatment etc.):

*We are confronted with very complex cases, often difficult family situations. We need to be able to reflect sometimes, to look at it from a distance, especially from our position, because these social workers come to us with their problems. Finally, the ethical responsibility ends here, at our level. We need to share this responsibility with an expert. (CS, group 5)*

Some psychologists and a psychiatrist of the psychiatric centre mentioned they had already given onsite lectures. Mostly this regards psychiatric topics with which practitioners in children's services or social services are commonly confronted (e.g. depression, ADHD, autism, auto-mutilation, etc.).

Practitioners in children's services asked to address short questions concerning a therapy, high- risk behaviour or medication over the telephone. This way, short and or urgent matters could be answered quickly.

Few participants of children's services currently had direct contact and collaboration when a child swapped child and adolescent psychiatry for children's services. The follow-up provided by child and adolescent psychiatry was often insufficient or inexistent. Many participants asked to be involved in the referral process, to be informed about the child and his or her problems in order to help direct the placement decision. Practitioners of child and adolescent psychiatry reported to have been confronted with this need. However, their duty of professional confidentiality often made this sharing of information difficult.

### **Context: Need for a supportive policy framework.**

All participants confirmed that the proposed collaboration could not be realized without a supportive policy framework. Until today collaboration had only occurred sporadically and by the grace of the goodwill of the professionals, called upon.

Practitioners of child and adolescent psychiatry said to be willing to meet the requests of children's services and had done so already. In most cases this was purely voluntary:

*It would be very good to collaborate, but until now there are no arrangements to facilitate this. Until now, it was strictly voluntary when we complied with a request from an institution. Between times we do this. (CAP, group 2)*

Participants of the psychiatric centre repeatedly reported the lack of structural financial compensation for most of these activities. A major part of the proposed solutions and collaborative processes are impossible to realize. Furthermore, participants of both services condemned the fact that some combinations of care cannot be realized as it is not allowed by law.

## **Discussion**

This study was part of a project aiming to improve the efficiency of the care for children in children's services. Unlike many other projects, the development of a collaborative model was a bottom-up process. The aim of this study was to assess the needs of professionals, based on focus groups, which would enable them to offer the best care possible for children with complex problems. Moreover, professionals of both children's services and a child and adolescent psychiatric centre were included in the assessment. As such, it was a unique design.

The focus groups revealed a great consensus concerning the primary goal and the outlines of the partnership. Services of both partners should be readily accessible and versatile to organize the best care possible for the child using each other's strengths. They wanted to realize this by supporting each other in their job, tasks and assignments, by offering relevant expertise and know-how. Children's services were ascribed the role of case manager, which they proposed themselves as well. Professionals of child and adolescent psychiatry saw themselves as expert consultant and were willing to respond to this need of expert support of children's services. The idea of designating one professional (group) as lead or coordinating service also emerged from the study of Stanley, Penhale, Riordan, Barbour, and Holden (2003). It appeared that childcare social practitioners were mostly nominated to fulfil this role, with the highest levels of support among themselves.

The importance of clearly defined roles and responsibilities for the success of joint working has been repeatedly subscribed previously and cannot be underestimated (Cameron & Lart, 2003). In this study, the participants didn't see the collaborative process as an incorporating, continuous collaboration. They also preferred clearly defined boundaries and role definitions, and wished them to be honoured. In addition, the need for a partnership did not concern all children in children's services, though especially those suffering serious and multiple (mental health) problems, disorders or handicap(s).

## **Service aspects and implications**

It was apparent that all participants of children's services encountered a wide range of mental health problems, many of which would meet the criteria of serious psychopathology or handicap. Many quantitative studies have indeed already illustrated the high prevalence rates among children in children's services (McCann, James, Wilson, & Dunn, 1996; Meltzer, Gatward, Corbin, Goodman, & Ford, 2003; Pilowsky, 1995). In addition, the professionals mentioned that the complexity of the cases had increased. This is consistent with previous studies where professionals raised this concern (Callaghan, Pace, Young, & Vostanis, 2003; Kelly, Allan,

Roscoe, & Herrick, 2003). This established fact forced professionals of children's services to call in the help of child and adolescent psychiatry.

The needs assessment of Worall and O'Herlihy (2001) revealed that psychiatrist ask for more beds and rate this high on the priority list. Practitioners of child and adolescent psychiatry in this study did not share this opinion, although they did confirm the long waiting lists and mentioned to be unable to comply with all the requests for hospitalization. However, they pleaded for better referrals and more ambulatory support for children's services professionals to prevent hospitalization.

It seemed that most of the obstacles dragged up during the focus groups had its origin in a lack of knowledge of the organization of the other service. Direct, face-to-face communication is seen as the key factor in determining the collaborative process. This would help them to get to know each other. Finally, this would have to lead to pull down the barriers between them. Eventually, it would also lead to gain respect and trust, indispensable to share information. Proposed good practices were: On the spot consultations on team-level in children's services, accompanying a client while coming to therapy, longer after-care from child and adolescent psychiatry, use of common observation and screening instruments, additional courses to the bachelor and master curricula leading to both services, and so on. All projects and initiatives stimulating direct contact should be supported.

### **Interagency working**

Collaboration should be considered within a new perspective. Practitioners of children's services and child and adolescent psychiatry in this study prefer case-level collaboration instead of system-level collaboration. Although, the latter is more commonly cited in literature and often promoted through government policy (Salmon, 2004).

Practitioners of both services pursue the same goal, which should be the primary concern when developing a partnership: The wellbeing of the child and its context. This has not always been the case, as reported by Sloper (2004) in his review. Of all the models of multiagency working used in practice, only one (the least common) aims to ensure that the service is co-ordinated at the point of delivery to children and families. The majority of the models were focused on the organization of professionals and will not necessarily ensure that families receive a coordinated service.

Sharing the same goal, they declined to be taken over by the other. Professionals refused the idea of a seamless integration of both services, but supported the idea of working together across organizational and professional boundaries. Interagency cooperation should be the preferred model, as it facilitates work and tasks and requires a minimum investment of all partners.

These two prerequisites are combined in the idea of an individualized service plan. The child and its context are the centre of the care planning process in which all partners are involved and the services of all partners are available when their care or support is requested during the service plan.



These ideas can only be put into practice within a supportive policy framework. The current legislation prohibits the realization of some of the participants' proposed good practices.

### **Methodological issues**

This study utilized the qualitative method of exploratory focus groups to collect data. This technique is especially useful for a needs assessment as it is able to capture feelings, perceptions and opinions of the participants. The interactive nature turns participants into active partners in the research process, asking questions of each other and of the researcher, which in turn facilitates disclosure (Kitzinger, 1994; MacDougall & Fudge, 2001; Powell & Single, 1996). The downside of this interactive method is that group norms may silence dissent opinions and researchers have few control over the data produced.

The generalizability of qualitative results remains difficult. The moderator of the focus groups was no member of the research team to avoid directive data collection. Analyses were performed following a standard procedure by two independent researchers to maximize reliability. There was partly participant validation: The results were presented to the representatives of children's services and all personnel of the child and adolescent psychiatric centre. The same presentation was given to members of child and adolescent psychiatric centres and children's services of the four remaining provinces. All four audiences agreed with the general results of the study, except in one province, where members of both sectors felt they had accurate and sufficient knowledge concerning the organization and service provision of the other services. The data verification and inclusion of representatives of all professional roles and practice contexts make it more possible to generalize the results of the study even though it was based on only one geographical area.

A more general limitation of the study stems from the reliance on the perceptions of the service providers alone. Accessing the account of children and adolescents of children's services would bring in valuable information, providing a counterbalance to the data obtained.

### **Implications for further research**

These findings require replication. In contradiction with many of the proposed solutions to improve the care for looked-after children, these professionals do not request an integration of both services. In addition, the children concerned need to be included in the needs assessment as well.

It is advisable that future collaborative processes are developed bottom up. Involving practitioners in the developmental process increases the chances on successful implementation, as they become active partners. Future models of multiagency collaboration should address the professionals' needs and all known facilitators and barriers to the success. Stevenson (1989) noted five major themes that at present still cover all revealed barriers. It is about time new initiatives address them appropriately.

Evaluation of joint working should be encouraged. Few studies on multiagency working have reported on service users' improvements, and the few evaluations that have been carried out were methodologically poor (Sloper, 2004). Mostly, they have

focused on the professionals' perspectives, providing insights on the process but no evidence on outcomes for users.

## **Conclusion**

A needs assessment based on focus groups proved to be a valuable methodology in the search for an efficient care model for children in children's services at risk for mental health problems. Several governments promoted the organisation of joint working. Often this resulted in the foundation of interagency teams involving professionals of different disciplines. This study, being part of a larger project with a bottom-up approach, questioned the professionals concerned. The focus groups revealed that professionals preferred the integration of the service provisions of children's services and child and adolescent psychiatry over the integration of the services itself. It is about inter-agency co-operation where the wellbeing of the child is the primary concern.

## **References**

Arcelus, J., Bellerby, T., & Vostanis, P. (1999). A mental health service for young people in the care of the local authority. *Clinical Child Psychiatry and Psychology*, 4, 233–245.

Brandon, M., Howe, A., Dagley, V., Salter, C., & Warren, C. (2006). What appears to be helping or hindering practitioners in implementing the Common Assessment Framework and lead professional working? *Child Abuse Review*, 15(6), 396–413.

Bruner, C., Kunesh, L. G., & Knuth, R. A. (1992). What does research say about interagency collaboration?

Oak Brook, IL: North Central Regional Educational Laboratory.

Burns, B., Costello, E. J., Angold, A., Tweed, D., Stangl, D., Farmer, E. M. Z., & Erkanli, A. (1995). Children's mental health service use across service sectors. *Health Affairs*, 14(3), 147–159.

Burns, B., Phillips, S., Wagner, R., Barth, R., Kolko, D., Campbell, Y., & Landsverk, J. (2004). Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8), 960–970.

Callaghan, J., Pace, F., Young, B., & Vostanis, P. (2003). Primary mental health workers within youth offending teams: A new service model. *Journal of Adolescence*, 26(2), 185–199.

Cameron, A., & Lart, R. (2003). Factors promoting and obstacles hindering joint working: A systematic review of the research evidence. *Journal of Integrated Care*, 11(2A), 9–17.

Costongs, C., & Springett, J. (1997). Joint working and the production of a City Health Plan: The Liverpool experience. *Health Promotion International*, 12, 9–12.

- Cottrell, D., Lucey, D., Porter, I., & Walker, D. (2000). Joint working between child and adolescent mental health services and the Department of Social Services: The Leeds Model. *Clinical Child Psychology and Psychiatry*, 5, 481–489.
- Darlington, Y., Feeney, J., & Rixon, K. (2004). Complexity, conflict and uncertainty: Issues in collaboration between child protection and mental health services. *Children and Youth Services Review*, 26, 1175–1192.
- Darlington, Y., Feeney, J., & Rixon, K. (2005a). Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. *Child Abuse & Neglect*, 29, 1085–1098.
- Darlington, Y., Feeney, J., & Rixon, K. (2005b). Practice challenges at the intersection of child protection and mental health. *Child and Family Social Work*, 10, 239–247.
- Denning, J. D., & Verschelden, C. (1993). Using the focus group in assessing training needs: Empowering child welfare workers. *Child Welfare*, 72(6), 569–580.
- Dowling, B., Powell, M., & Glendinning, C. (2004). Conceptualising successful partnerships. *Health and Social Care in the Community*, 12(4), 309–317.
- Friedman, S. R., Reynolds, J., Quan, M. A., Call, S., Crusto, C. A., & Kaufman, J. S. (2007). Measuring changes in interagency collaboration: An examination of the Bridgeport Safe Start Initiative. *Evaluation and Program Planning*, 30(3), 294–306.
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 38, 581–586.
- Hallett, C., & Birchall, E. (1992). *Co-ordination and child protection: A review of the literature*. London: HMSO.
- Hetherington, R., Baistow, K., Katz, I., Mesie, J., & Trowell, J. (2002). *The welfare of children with mentally ill parents: Learning from inter-country comparisons*. Chichester: John Wiley & Sons.
- Johnson, M. O. (2001). Meeting health care needs of a vulnerable population: Perceived barriers. *Journal of Community Health Nursing*, 18(1), 35–52.
- Johnson, P., Wistow, G., Schulz, R., & Hardy, B. (2003). Interagency and interprofessional collaboration in community care: The interdependence of structures and values. *Journal of Interprofessional Care*, 17(1), 69.
- Kelly, C., Allan, S., Roscoe, P., & Herrick, E. (2003). The mental health needs of looked after children: An integrated multi-agency model of care. *Clinical Child Psychology and Psychiatry*, 8(3), 323–335.
- Kitzinger, J. (1994). The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health and Illness*, 16, 103–121.
- Kitzinger, J. (1995). Introducing focus groups (Qualitative Research, part 5). *British Medical Journal*, 311(7000), 299–303.
- Knitzer, J., & Yelton, S. (1990). Collaborations between child welfare and mental health. *Public Welfare*, 48(2), 24.

- Krueger, R. A. (1998). *Moderating focus groups: The focus group kit* (Vol. 4). Thousand Oaks, CA: Sage.
- Lyons, J. S., & Rogers, L. (2004). The U.S. Child Welfare System: A de facto public behavioral health care system. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(8), 971–973.
- McCann, J., James, A., Wilson, S., & Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal*, 313, 225–233.
- MacDougall, C., & Fudge, E. (2001). Planning and recruiting the sample for focus groups and in-depth inter-views. *Qualitative Health Research*, 11(1), 117–126.
- Mattessich, P. W., Murray-Close, M., & Monsey, B. R. (2004). *Collaboration – What makes it work*. St Paul, MN: Amherst H. Wilder Foundation.
- Meltzer, H., Gatward, R., Corbin, T., Goodman, R., & Ford, T. (2003). *The mental health of young people looked after by local authorities in England*. London: The Stationery Office.
- Morrison, T. (1996). Partnership and collaboration: Rhetoric and reality. *Child Abuse & Neglect*, 20(2), 127–140. Nicholas, B., Roberts, S., & Wurr, C. (2003). Looked after children in residential homes. *Child and Adolescent Mental Health*, 8(2), 78–83.
- Pilowsky, D. (1995). Psychopathology among children placed in family foster care. *Psychiatric Services*, 46(9), 906–910.
- Powell, R., & Single, H. (1996). Focus groups. *International Journal of Quality in Health Care*, 8, 499–504. Quinn, K., & Cumblad, C. (1994). Service providers' perceptions of interagency collaboration in their communities. *Journal of Emotional & Behavioral Disorders*, 2(2), 109.
- Race, K. E., Hotch, D. F., & Parker, T. (1994). Rehabilitation program evaluation: use of focus groups to empower clients. *Evaluation Review*, 18(6), 730–740.
- Salmon, G. (2004). Multi-agency collaboration: The challenges for CAMHS. *Child and Adolescent Mental Health*, 9(4), 156–161.
- Secker, J., & Hill, K. (2001). Broadening the partnerships: Experiences of working across community agencies. *Journal of Interprofessional Care*, 15(4), 341–350.
- Sloper, P. (2004). Facilitators and barriers for co-ordinated multi-agency services. *Child: Care, Health and Development*, 30(6), 571–580.
- Stanley, N. (2005). Developing structures and training for new partnerships in child protection. *Child Abuse Review*, 14(5), 293–296.
- Stanley, N., Penhale, B., Riordan, D., Barbour, R. S., & Holden, S. (2003). Working at the interface: Identifying professional responses to families with mental health and child-care needs. *Health and Social Care in the Community*, 11(3), 208–218.
- Stevenson, O. (1989). *Child abuse: Professional practice and public policy*. London: Harvester Wheatsheaf. Stiffman, A. R., Hadley-Ives, E., Doré, P., Polgar, M., Horvath, V. E., Striley, C., & Elze, D. (2000). *Youths' access to mental health*

services: The role of providers' training, resource connectivity, and assessment of need. *Mental Health Services Research*, 2(3), 141–154.

Strauss, A., & Corbin, T. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. London: Sage.

Williamson, V. (2001). The potential of project status to support partnerships. In S. Balloch & M. Taylor (Eds.), *Partnership working: Policy and practice* (pp. 117–141). Bristol: Polity Press.

Worall, A., & O'Herlihy, A. (2001). Psychiatrists' views of in-patient child and adolescent mental health services: A survey of members of the child and adolescent faculty of the College. *Psychiatric Bulletin*, 25, 219–222.

## APPENDIX FOUR

### Challenges and learning needs plan

This is your challenges and learning needs plan as to how you will complete the course.

	<b><i>Challenge 1</i></b>	<b><i>Challenge 2</i></b>	<b><i>Challenge 3</i></b>
<b><i>Identify the main challenges to completing the course</i></b>			
<b><i>For each challenge identify your action steps and learning needs on how to tackle this</i></b>			

<b>Identify the timescale for tackling the challenge</b>			
<b>Evaluate how this has worked. If it hasn't worked, identify another way to meet the challenge</b>			

**Module one**

**International issues and framework for borderline practice**

**Part two: Roles and services**

**Face-to-face day**

## ***Contents***

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## ***About this module***

This is the first module of the course. The module is called *International issues and frameworks for borderline practice*. The module will allow you to find out about the roles, services, frameworks and legal aspects of the other professional practitioners who work at the borderline with children and young people. It will also provide an international perspective by introducing you to the way in which this work is carried out across the six countries taking part in the course.

The first day of this module is a face-to-face day. On your face-to-face day, you will be working in your groups with your tutor. This handbook outlines the activities you will undertake on the face-to-face day. It has clear guidance on what objectives should be met at the end of each activity.

At the end of your face-to-face day, you will be given the handbook on how to complete the remainder of this module. The remaining study will be undertaken by self-study and e-learning. You will be expected to carry out reading and activities and also to access the online platform. Guidance on what is expected will be given by your tutor at the end of this face-to-face day.

### ***Module One: International issues and frameworks for borderline practice***

This module provides the opportunity for the professionals involved in borderline practice to explain to each other what they do and how their services are structured. It also provides the opportunity to develop an international perspective on borderline practice. The **aim** of the module



is to explore the structures, roles, ethical codes and philosophy underpinning approach to practice with young people

The **objectives** of the module are

- To learn about global and European perspectives in relation to mental health and residential child care
- To explore the policy and legal underpinnings of practice within each of the professional areas
- To explore the codes of practice which guide work in each of the professional areas
- To ensure that participants are familiarised with some of the common diagnoses in mental health services
- To examine the critiques of the medical model
- To ensure that participants are familiarised with the historic development of group care
- To outline the key ideas from social pedagogy and child and youth care (CYC)

### **Day Two: Face-to-face day**

- 9.00 – 9.15: Arrival, registration and re-orientation
- 9.15 -10.00: Who do we work with?
- 10.00 – 10.30: Working at the borderline: What do we mean by inter-professional practice?
- 10.30 – 10.45: Break
- 10.45 – 11.30: Why do we do what we do?

11.30 – 12.30:	Where do we get the authority to do our work?
12.30 – 1.30:	Lunch
1.30 – 1.45:	After lunch plenary and activity
1.45 – 2.30:	Care ethics and case study
2.30 – 2.45:	Break
2.45 – 3.30:	Global definitions
3.30 – 4.30:	Preparation for e-learning and evaluation

### **Activity 1 : Arrival, registration and re-orientation**

**Time to complete the activity: 15 mins**

**Objectives :** Participants will

- Feel comfortable in the training
- Get an opportunity to have re-orientate yourself to the group

Your tutor will lead you through an introductory activity, re-state the ground rules and go over the programme for the day.

## **Activity 2 : Who do we work with?**

**Time to complete the activity:** 45 mins

**Objectives :** Participants will

- Reflect on the characteristics of the young people with whom they work
- Examine the European and Global picture relating to some of the issues identified
- Discuss similarities and differences in young people who are the clients of different professional groups.

For this activity you will work in your professional learning sets. Discuss your own workplaces and the types of children and issues with whom you work. Note your findings below

**A picture of the young people we work with**

Where do they come from?  
poverty?

How big an issue is

(Any particular areas?)

Are the young people affected by any specific issues (e.g. drugs, self-harm)

or do they have a diagnosis of mental disorder?



Are their parents/carers affected by any issues (e.g. diagnosis of mental illness, substance misuse?)

What is the family structure like?

What age are they?

What is their ethnicity?

What is their school attendance like?

Each group should now present the picture that has emerged about the young people with whom they work. Once each group has presented this, the whole group should discuss the similarities and differences between the young people.

Now read the following short extract and once you have read it, discuss how this links to your findings about the young people with whom you work.

### **Mental Health: The Global and European Picture**

Mental health was established as a priority on the global agenda by the World Health Report of 2001 *Mental Health: New Understanding, New Hope*, which was endorsed by the World Health Assembly of the World Health Organisation (WHO) in 2002. In Europe, in 2005, the Regional Office of the WHO adopted the Helsinki Declaration and Action Plan at a special Ministerial Conference held in Helsinki.

These Reports and Declarations set an agenda for action to support rights for people with mental health problems and develop community based services. The European Commission launched its European Pact on Mental Health and Wellbeing in 2008 and the European Union has now established a Joint Action on Mental Health and Wellbeing starting in 2012.

In Europe , it is estimated that mental disorders affect more than a third of the population every year, the most common of these being depression and anxiety. About 1-2% of the population have psychotic disorders, and across Europe 5.6% of men and 1.3% of women have substance misuse disorders.

In all countries, most mental disorders are more prevalent among those who are most deprived. The prevalence of mental disorders does not appear to be changing significantly over time, though more people are accessing treatment and support as understanding grows and the stigma of mental illness is reducing.

Across Europe, neuropsychiatric disorders are the second largest contributor to the burden of disease , accounting for 19% of the total. There is considerable variation across Europe, with mental disorders already ranked highest in many high income Western European countries, but only fourth or fifth in some low income countries due, in part, to the continuing high prevalence of perinatal and cardiovascular diseases. Mental disorders are by far the most significant of the chronic conditions affecting the population of Europe, accounting for just under 40% of all years lived with disability.

A high percentage of people who receive social welfare benefits or pensions because of disability have, as their primary condition, mental disorders. Data from countries where information is available show that people with mental disorders account for as much as 44% of social welfare benefits or disability pensions in Denmark, 43% in Finland and in Scotland and 37% in Romania. Rates of employment for people with mental health problems in Europe vary between 18%- 30%. Higher figures for social welfare benefits do not necessarily indicate higher levels of illness, but reflect a combination of reporting arrangements, levels of stigma and discrimination and the different scope of welfare systems across Europe.

Mental disorders are strongly related to suicide. Suicide rates in Europe are high compared to other parts of the world. The average annual suicide rate in Europe is 13.9 per 100,000, but there is a wide variation. There are reports that suicide rates have been rising in Europe since 2008, with the greatest increases in those countries most affected by the economic recession.

Research carried out in the UK and elsewhere consistently shows that children in residential care have significantly poorer mental health than the rest of the population. Work with this particular group is often made more complex by the strong feelings which can be evoked in care-

givers and professionals by children who are struggling to cope with and come to terms with a personal history of trauma including abuse and neglect. Services work best for children where work has been done to develop a shared understanding of thresholds, where good professional relationships between individuals from different agencies have been allowed to build up, and where there is confidence that new referrals for assessment will be given appropriate priority.

[This extract was adapted from the introduction to the Mental Health Strategy for Scotland 2012-2015, accessed on 28<sup>th</sup> August 2013 at [www.scotland.gov.uk/Resource/0039/00398762.pdf](http://www.scotland.gov.uk/Resource/0039/00398762.pdf) . Links to the other papers referred to in this extract can be found below:

Mental Health: New Understanding, New Hope (2001) accessed on 28th August 2013 at [www.who.int/whr/2001/en/index.html](http://www.who.int/whr/2001/en/index.html)

Helsinki Declaration and Action Plan (2005) accessed on 28th August 2013 at [www.euro.who.int/\\_data/assets/pdf\\_file/0008/88595/E85445.pdf](http://www.euro.who.int/_data/assets/pdf_file/0008/88595/E85445.pdf)

European Pact on Mental Health and Wellbeing (2008) accessed on 28th August at

[http://ec.europa.eu/health/mental\\_health/docs/mhpact\\_en.pdf](http://ec.europa.eu/health/mental_health/docs/mhpact_en.pdf)

Joint Action on Mental Health and Wellbeing (2011) accessed on 28th August 2013 at <http://register.consilium.europa.eu/pdf/en/11/st10/st10384.en11.pdf>

**How similar are the issues with which both mental health professionals, residential practitioners and social pedagogues work?**

**Activity 3 : Working at the borderline: What do we mean by inter-professional practice**

**Time to complete the activity: 30 mins**

**Objectives :** Participants will

- Define what they mean inter-professional practice
- Begin to identify barriers to inter-professional practice

Working at the borderline is that area where professionals meet. The best approach to work at the borderline is to have positive inter-professional practice. An examination of inter-professional practice in

the public services seems to indicate that practitioners have struggled with the best ways to provide help for young people at risk. While there can be no doubt about the desire for much greater collaboration this does not mean that such practice is easy to achieve or even very straightforward to translate into practice. Differences in power, orientation and interests can lead to conflicts or rivalry.

These are major issues that need to be recognised and tackled before effective inter-professional practice is likely to take place. Simply having a desire to work across professional boundaries, or even the existence of legislation or policy at the country level are in themselves not sufficient to deal with issues arising from power differentials between professional groups, the influence of professional identity and how the interests of various professionals can be accommodated.

Today, we want to explore the real barriers to inter-professional work but also to show that when recognised and addressed, these can become bridges which connect professionals involved with young people and their families, and produce more effective service delivery.

A good starting point is to explain what we think we mean by inter-professional practice. For this activity, the group should split into its two professional learning sets and each group should come up with a definition of inter-professional practice. They should each then present their definition to the other group. Discuss the definitions in the larger group to come up with a definition that everyone agrees on. Note this large group definition below:

**Our group definition of inter-professional practice:**

Your tutor will now facilitate some discussion on any issues which arose when you were discussing your definitions.

**Activity 4: Why do we do what we do?**

**Time to complete the activity:** 45 mins

**Objectives:** Participants will:

- Explore their individual motives for entering their profession and becoming their type of practitioner
- To examine some of the philosophical concepts around care and discuss these as they apply to their own work

- To explore how the different motivations and understandings of their work create differences in their approach to young people

For this activity, you will be working in your inter-professional learning set.

Each inter-professional learning set should discuss why they entered the profession. What drew you to it? Do you think it is a part of you as a person or do you see it in purely professional terms? After your discussion, read the following extract:

*In the course of developing her ethic of care, Tronto outlines four levels of caring – 1. **caring about**, 2. **taking care of**, 3. **care-giving**, and 4. **care-receiving** (1994: 105-108). The position of mental health practitioners and residential workers can be analysed in terms of these levels. This analysis helps us to identify some of the tensions and conflicts between them. Tronto argues that the four levels of care coincide with specific positions of status within the structure of society. She suggests that, **caring about** and **taking care of** occupy the public domain of the more powerful. Caring about is, for Tronto, the public manifestation of the nominal willingness to care, and is the subject discussed when, for example, politicians talk about caring. Taking care of is likewise a public activity. It results from the policy making of the more powerful groups and is translated into action by government agencies. Caring about and taking care of make up those aspects of care that are public and accountable in terms of the rational-scientific analysis.*

*On the other hand, **care-giving** and **care-receiving** are generally relegated to the private domain of the less powerful. These private activities of care have mainly been the work of women in Western society. Care-giving represents the particularisation of the intention to care — it is care removed from the realm of the public and enacted in a context. One example of this would be the tasks of direct care (such as making a meal) performed by a residential worker in a children's unit. In this type of relationship, the care-giver is in direct interaction with the care-receiver. **Care-receiving** occupies a position different from the former three levels. The care-receiver is not viewed as the modern ideal of the independent individual. Care-receiving implies neediness and dependence. For example, a child in a residential unit or mental health context would be the care-receiver in this analysis. So in conclusion, while caring about and taking care of represent the public, the universal, and the rational aspects of caring, care-giving and care-receiving represent the private, the menial, and the emotional aspects. The first two areas have greater status than the last two areas, and these perceptions can have a real impact on inter-professional practice. (Milligan and Stevens, 2007)*



## **Activity**

In your inter-professional learning set, think about and discuss Tronto's four levels of care. Which level do you think the mental health professional occupies? Which level do you think the residential practitioner or social pedagogue occupies? In relation to financial terms and conditions of work, is one more valued than the other? Is your practice an engendered profession?

### **Activity 5: Where do we get the authority to do our work?**

**Time to complete the activity:** 60 mins

**Objectives:** Participants will:

- Outline the legal and policy basis for their work
- Outline the ethical or professional codes of practice which they must follow in their work
- Present these to their fellow participants
- Discuss area of similarity and difference

For the first part of this activity, participants should work in their professional learning sets. Each group should complete the following questions and be prepared to present this to the full group when it is completed.

Once the presentation is complete, a brief summary of any points of similarity and difference should be noted between the professional groups. The answers to the questions for each professional group and the notes from the brief summary should be posted onto the online platform before the end of today.

*Country:*

*Our job titles are:*

*The kind of organisations / services that our work takes place in is/are:*

*The legislation by which young people are referred to my service, and the key points of this legislation is/are:*

*Is my profession/service regulated by the state? YES / NO*

*If yes, the qualifications / experience by which I can register as a practitioner are:*

*The professional body with which I have to register to practice is:*

*The name of the professional code of practice to which I must adhere as the above named type of practitioner is:*

### **Activity 6: Care ethics and case study**

**Time to complete the activity:** 45 mins

**Objectives:** Participants will:

- Discuss the concept of care ethics
- Apply the concepts to a case study

For this activity, you will be working in your inter-professional learning set. First of all, read the following extract on care ethics:

*One of the emerging fields of philosophy as applied to the helping professions is care ethics. Noddings is one of the main proponents of care ethics. She suggested that care is not happening unless the person who is cared-for actually experiences the feeling of being cared-for by a care giver. Noddings says that the experience of actually being*

*cared for makes the care-receiver feel like a subject. She is critical of some of the agencies set up to care:*

*The fact is that many of us have been reduced to cases by the very*

*machinery that has been instituted to care for us.*

*(1996: 27)*

*The field of care ethics is becoming a much more widely debated area for field social care, education and health care. For example, Prior (2005) discussed the place of virtue ethics in helping professionals to conceptualise their task. Virtue ethics are those which emphasise moral character, in contrast to the approach which emphasizes duties or rules (deontology). A virtue is a disposition which is well entrenched in its possessor, something that a deep and integral part of their being. A virtue is concerned with actions, emotions and emotional reactions, choices, values, perceptions, attitudes and interests. Virtues must be accompanied by phronesis or practical wisdom, and eudaimonia or happiness. In other words, a virtue must be practiced in the conduct of living and working, and the practice of that virtue must be central to the person`s sense of happiness or well-being. To possess a virtue is to be a certain sort of person. Prior suggests moving away from sole reliance on the rational-scientific approach and instead to pay attention to how practice has developed through traditions, history and `small narratives`. By adopting such perspectives, the helping professions can begin to re-think the basis of practice:*

*The concept of practice can be used to explain shared understanding. Through participating in a practice ... citizens can attain virtues inherent in practice. It is through communities of practice that virtues ....come to be held in common since such communities develop shared meanings that unite them. In other words communities define the virtues of a practice and in so doing develop shared meanings. (2005: 24)*

*Care ethics and debates such as these may provide one of the keys to bringing conceptualisations of residential child care and mental health practice closer together, and thus developing a deeper shared basis for inter-professional practice.*

Have a brief discussion about the extract you have just read on care ethics. Then read and discuss the following case study:

**You are working with Anna, a 14 year old young person who has been placed with you, due to issues around self-harm. The young person has been cutting themselves, misusing drugs and is sexually promiscuous. As a residential worker, social pedagogue or as a mental health professional, what kind of contact do you think you would have with the young person? What would your actual day to day contact be like? What feelings do you have for**

**the young person and how do they guide your work? What drives your work? How do you decide how to prioritise the work that needs to be done? How do you make sure the young person experiences and feels care?**

Draw out the similarities and differences in the way you work with the young person. Link this to the extract on care ethics. Note the main points of your discussion and feed these back to the other learning set.

### **Activity 7 : Warm up after lunch**

**Time to complete the activity:** 15 minutes

**Objectives :** Participants will

- Feel comfortable in the afternoon session
- Get an opportunity to have some fun and waken up
- Reflect briefly on the morning and be introduced to the afternoon session

Your tutor will lead you through a warm up activity

### **Activity 8: Global definitions**

**Time to complete the activity:** 45 minutes

**Objectives :** Participants will

- Begin to explore global codes of definitions of nursing and social work/social pedagogy
- Identify areas

It is recognised that the participants on the course will be from diverse professions, backgrounds, education, countries and cultures. This course is one opportunity to reflect on the global nature of work with young people at risk and how it is carried out. The group has just heard about how their own country legislates for and defines its practice. We will now begin to examine these aspects from a global perspective.

Consider the three globally recognised definitions below:

1. *Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles [International Council of Nurses]*

2. *The social work profession (including social pedagogy) promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work [International Federation of Social Workers]*
  
3. *Kornbeck and Rosendal Jensen (2009) note that 'social pedagogy as an idea, a concept, a pedagogical movement and a profession has by and large found broad European acceptance, although the understanding and use of the concept differs from country to country' (p. 3). For instance, Danish social pedagogy has distinct differences from its German, French or Dutch counterparts... Despite the differences resulting from various cultural contexts as well as different settings there are shared principles connecting these social pedagogic traditions, which underpin the four overarching aims of social pedagogy: to enhance well-being and happiness, both at an individual and collective level as well as in the short and long term; to provide holistic learning opportunities and positive experiences throughout the life course; to develop strong, caring and authentic relationships so that people experience themselves as interconnected, as supported by and responsible for others; and to enable individuals and communities to empower themselves, taking responsibility for and control over their own lives [Eichsteller and Holthoff, 2011]*

In your inter-professional learning sets, read and discuss the definitions above. What are the main similarities? What are the main differences? Then come together in the full group to discuss your thoughts. Consider your work with young people at risk. How do the definitions actually apply to your work?

### **Activity 9: Preparation for e-learning and evaluation**

**Time to complete the activity:** 60 minutes

**Objectives :** Participants will

- Receive guidance on what should be compiled in their portfolio of learning for the course
- Ensure that they have a copy of the presentations which will be put onto the online platform
- Complete an evaluation form for the face-to-face day to provide feedback on how this has gone
- Go over the expectations and time scales for the e-learning section of this module

You should either save a copy of the presentations onto a pen drive or print a copy of the presentations. The presentations should be kept in a portfolio which you will compile throughout the course. The section headings of the portfolio are contained in Appendix One of this handbook. You should print these out or remove them from this handbook and put them into a ring binder. This will form your record of learning for the course and will form the foundation for your final research and development report.

Please also complete the evaluation form at the end of this handbook and hand it to your tutor.

### **Preparation for e-learning**

The remainder of this module will be completed by you through self study and e-learning. Your tutor will now go through the handbook for part three of this module, which guides you through what is required to complete this module. You will receive an electronic copy of this handbook, as some of the activities contain links to websites. These



links are most easily accessed by having your handbook uploaded onto your computer and internet.

## **References**

Eichsteller, G. & Holthoff, S. (2011). Conceptual Foundations of Social Pedagogy: A Transnational Perspective from Germany. In C. Cameron & P. Moss (Eds.), *Social Pedagogy and Working with Children and Young People*. London: Jessica Kingsley

Kornbeck, J. & Rosendal Jensen, N. (2009). *The Diversity of Social Pedagogy in Europe*. Bremen: Europäischer Hochschulverlag.

Milligan, I. & Stevens, I. (2007). *Residential child care: collaborative practice*. London: Sage.

Noddings, N., Gordon, S. & Benner, P. (1996) *Caregiving: Readings in Knowledge, Practice, Ethics and Politics*. Pennsylvania: University of Pennsylvania Press.

Prior, J. (2005). *A Genealogy of Social Work: Moral Enquiry for Education*. University of Strathclyde, PhD thesis.

Tronto, J.C. (1994). *Moral Boundaries: A Political Argument for an Ethic of Care*. London: Routledge.

## **Appendix One**

### **Portfolio sections**

#### **Section One**

- **Personal profile**

- **Individual learning plan**
- **Ongoing evaluations of course and learning**

## **Section Two: Evidence of learning from Module One**

### ***International issues and framework for borderline practice***

- **Notes from face-to-face day for module one**
- **Copies of presentations on legal and professional aspects from other professional group/s in your own country on face-to-face day**

- Piece of reflective writing on what you learned from the 5 other country presentations
- Your reflection on international definitions of professions and international codes of practice
- Your critical appraisals for mental health or residential care/social pedagogy
- Your reflection on learning from Module One and part one of your anonymised case study

### **Section Three: Evidence of learning from Module Two**

#### ***Problems that practitioners face in everyday work***

- Notes from the face-to face days
- Case study parts 1-6
- Reflection on similarities and differences between countries on images of childhood and better collaboration with parents
- Reflection on culturally sensitive practice
- Reflection on work with substance misuse and self-harm
- Critical reflection on similarities and differences between cases worked on in each country and what you have learned from this about inter-professional practice challenges and promoters.

#### **Section Four: Evidence of learning from Module Three**

##### ***Challenges and benefits of inter-professional collaboration on the borderline***

- **Notes from the face-to-face days**
- **Reflection on organisations**
- **3 reflective writing pieces from placement**
- **Work shadowing report from placement**
- **Mind map for your research and development report**

**Evaluation form**

**Face-to-face day: Module one**

**Can you please provide some comments on the following:**

<b>The handbook</b>	
<b>The methods used (groupwork, tutor input etc)</b>	
<b>Tutor support</b>	
<b>Venue</b>	

<b>Content of the face-to-face day</b>	
<b>Standard of work expected</b>	
<b>Guidance on what you had to do for your portfolio</b>	

***Module one***

***International issues and framework for borderline practice***

***Part three: Self study and***

***e-learning***



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### ***Introduction***

Welcome to this handbook. It contains information and instructions on how to complete Module One. For this part of the module you will be working independently and you will need to be able to access information from the internet and from the online platform. As you progress through the handbook, you will be guided on what you should incorporate into your portfolio. To remind you, the objectives of the module are

- To learn about global and European perspectives in relation to mental health and residential child care
- To explore the policy and legal underpinnings of practice within each of the professional areas
- To explore the codes of practice which guide work in each of the professional areas
- To ensure that participants are familiarised with some of the common diagnoses in mental health services
- To examine the critiques of the medical model
- To ensure that participants are familiarised with the historic development of group care
- To outline the key ideas from social pedagogy and child and youth care (CYC)

On your face-to-face day, you worked on objectives 1-3. For the remainder of the module, you will be working on objectives 4-7 and you will also be extending your knowledge of international perspectives. You will be getting to know your international colleagues much better by using the online platform.

Part of the material in this handbook is optional and part of the material is mandatory. This is because we know that you will have expertise relating to your own particular professional field. Therefore, the learning material relating to objectives 4 and 5 will be mandatory for residential workers or social pedagogues but it will only be optional for mental health professionals. Similarly, if you are a mental health professional, material relating to objectives 6 and 7 will be mandatory but this will only be optional for residential workers and social pedagogues.

In SECTION ONE of the handbook, international perspectives will be developed and you will be expected to use the online platform.

In SECTION TWO of the handbook, the topic of mental health will be explored. This section is **MANDATORY FOR RESIDENTIAL STAFF/SOCIAL PEDAGOGUES**. It is optional for mental health professionals.

In SECTION THREE of the handbook, the topic is residential group care. This section is **MANDATORY FOR MENTAL HEALTH PROFESSIONALS**. It is optional for residential staff/social pedagogues.

***Section One: International perspectives***

### **Activity 1 : Getting to know my international colleagues**

#### **MANDATORY FOR ALL PARTICIPANTS**

**Objectives :** Participants will

- Look at the personal profiles for each of the other countries who are taking part
- Begin to get familiar with your fellow participants

This activity will be undertaken on your own. To complete the activity:

1. On the online platform, there are six country folders. These are Denmark, Finland, Lithuania, Germany, Spain and Scotland.
2. Within each of the country folders, there will be personal profiles for each of the participants which will have been uploaded on the first face-to-face day
3. Click on each country in turn, except your own, and read the personal profiles. As you do this, fill in the grid overleaf
4. Once you have filled in the grid, spend some time thinking about the similarities and differences between the countries in terms of the workforce. In particular, make a note of anything that surprises you and also any points that you would like to be clarified.
5. Remember to allocate enough time for this activity as there are many profiles to read !!

<b>Country -&gt;&gt;</b>					
<b>First names of mental health staff participants</b>					
<b>Types of qualifications</b>					

<b>Types of workplace</b>					
<b>First names of residential child care/social pedagogue participants</b>					
<b>Types of qualifications</b>					
<b>Types of workplace</b>					

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**Activity 2: Getting to know the other countries**

**MANDATORY FOR ALL PARTICIPANTS**

**Objectives:** Participants will:

- Look at the presentations for each country
- Analyse the similarities and differences in the legal picture and professional/ethical codes of participants on the course

This activity builds on the previous activity. Each of the participating countries will have put their presentations in their country folder as you did within your group. For this activity:

1. Go on to the online platform and click on your own country. Read over your own presentations again just to remind yourself of the content and what to expect when you look at the other countries
2. Now work your way through the other countries. Click on each country folder in turn, look at the presentation and take some notes about the information contained in them.
3. Once you have done this, think about the information and draw out any similarities or differences between countries and also between other countries and your own country. Record this in a short piece of reflective writing. The guidelines on what to write are contained on the next page.
4. At the start of the next module, you will be discussing your thoughts with your fellow group members. As a group, you will be expected to come up with a short commentary and any questions you have for each of the countries. So it is important to record your thoughts in your reflective writing. Your reflective writing for this activity should also be put into your portfolio.

Write a short piece of reflective writing about what you have learned from looking at the presentations from the 5 other countries. Think about any part of this reading which caused you to stop and think, and about how the learning may impact on your inter-professional practice in the future. This log should be put into your portfolio.

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

**How this may affect my future practice**



### **Activity 3: International perspectives on ethics and professions (a)**

**Objectives :** Participants will

- Look at international perspectives on a profession other than their own
- Examine international codes on a profession other than their own

### **MANDATORY FOR MENTAL HEALTH WORKERS (OPTIONAL FOR RESIDENTIAL STAFF/SOCIAL PEDAGOGUES)**

Read the following paper and critically appraise it, using the critical appraisal tool in Appendix Two. Reflect on what the content may mean for inter-professional practice and note your main thoughts. Write these brief reflections on the next page.

***Defining social work for the 21st century: The International Federation of Social Workers' revised definition of social work***

<http://www.sagepub.com/jimenezstudy/articles/Hare.pdf>

Now read the following international code of professional ethics for social work. Reflect on the content and note if you think this goes against any of your own practice. Write these brief reflections on the next page.

***The International Federation of Social Workers Statement of Ethical Principles***

<http://ifsw.org/policies/statement-of-ethical-principles/>

**My reflections on the paper and the code for social work**

**Activity 4: International perspectives on ethics and professions (b)**

**Objectives :** Participants will

- Look at international perspectives on a profession other than their own
- Examine international codes on a profession other than their own

**MANDATORY FOR RESIDENTIAL STAFF/SOCIAL PEDAGOGUES  
(OPTIONAL FOR MENTAL HEALTH STAFF)**

Read the following paper and critically appraise it, using the critical appraisal tool in Appendix Two. Reflect on what the content may mean for inter-professional practice and note your main thoughts. Write these brief reflections on the next page.

***Child and adolescent mental health in Europe: Research on best practice.***

<http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/eurohealth/VOL15No4/Puras%20Vol15No4.pdf>

Now read the following international code of professional ethics for social work. Reflect on the content and note if you think this goes against any of your own practice. Write these brief reflections on the next page.

***The International Council of Nurses Code of Professional Ethics***

<http://www.icn.ch/about-icn/code-of-ethics-for-nurses/>

**My reflections on the paper and the code for nursing/mental health**

**Activity 5: Video clips**

**Objectives :** Participants will

- Identify video clips to show how they practice in their country
- Place the video clips onto the online platform

The medium of film is very powerful for illustrating how practitioners approach their work. This is especially important when working on the borderline and across countries.

See if you can identify some short video clips which illustrate a small part of how you work or how you are regulated. This may be a promotional video for your agency or organisation. It may be a video made by the government. Or it may be a 'YOU TUBE' clip which you have found that says a little about how things are done in your country.

Once you have identified the clip, load it onto the online platform. You will have the opportunity to see clips from the six countries taking part.

***Section two: Labelling and normality- Introducing mental health***

***This section is mandatory for residential staff and social pedagogues and optional for mental health professionals***

### ***About this section***

For the purposes of this section, we use the concept of 'mental disorder' as this is the World Health Organisation terminology, but this concept will be explored and challenged as a problematic concept in its own right. The section will allow you to explore how mental illness is defined and the effects of labeling.

The concept of the health / illness continuum in relation to mental health will be explored. Mental disorders covers a very wide spectrum; from the worries and grief we all experience as part of everyday life, to the most bleak, suicidal depression or complete loss of touch with everyday reality.

Mental disorders only become problematic when they interfere with the young person's ability to cope or function on a day-to-day basis or when their behaviour becomes a concern for others. The more extreme forms of distress can be very disturbing both for the young person experiencing the distress and for those around them.

However, while this distress can lead to considerable disruption and difficulty in a young person's life, they can be supported to find ways of understanding and managing the issues, and go on to meet their full potential.

Young people who receive interventions from mental health services, do so on the basis of a diagnosis. It is helpful to know what particular diagnoses mean. It is also helpful, however, to examine the impact of labelling as a sociological concept.

The **objectives** of this section are:

- To familiarise participants with some of the common diagnoses in mental health services
- To examine the critiques of the medical model, including labelling theory, the anti-psychiatry perspective and postmodernist viewpoints
- To critically appraise some of the research in this area

### **Activity one: Appraising the research**

**Objectives:** Participants will:

- Examine some of the ideas around mental health
- Reflect on what these mean for practice

Using the critical appraisal tool in Appendix One, you are asked to look at three papers and record your views.

The first paper is a summary of a famous experiment carried out in the 1970s. The experiment was carried out by a psychologist called David Rosenhan and was called 'Being sane in insane places'. The summary can be found on this link:

<http://www.holah.co.uk/study/rosenhan/>

If you like, you can also watch this short clip of David Rosenhan talking about the experiment.

<http://www.youtube.com/watch?v=qrcuUwTYww0>

Following the critiques thrown up by experiments like the Rosenhan study, psychiatry had to question itself and the rationale for its existence. The development of modern drugs which help to alleviate the symptoms of mental disorders has been seen as one way in which psychiatry contributes to positive mental health.

The second paper you will be asked to read is called *Flashpoint: children, adolescents and psychotropic medications*. It is a literature review about the use of 'psychotropic drugs' in children and adolescents. The paper was written for the American context but includes literature from around the world. Read pages 1-15 and also read the section entitled 'Benefits and Risks' from page 22 – 27. The paper can be found on:

[http://www.slhi.org/pdfs/issue\\_briefs/ib-2006-August.pdf](http://www.slhi.org/pdfs/issue_briefs/ib-2006-August.pdf)

*Having looked at the medication used, is this the same as the young people with whom you work, or are there different or new medications used?*

The third paper is by Margaret de Jong and is called *Some reflections on the use of psychiatric diagnosis in the looked after or "in care" child population*. De Jong is concerned about 'poly diagnosis' which is where a young person meets some criteria for a number of psychiatric diagnoses, and also about 'sub-thresholds' where young people meet almost all of the criteria for a number of disorders but are just below the number of criteria to receive a diagnosis. Read the paper at the link



below, using the critical appraisal tool. What do you think about these concerns? Do they reflect your practice or experience with troubled young people?

<http://ccp.sagepub.com/content/15/4/589.long>

### **Activity two: Demographics and policy**

**Objectives:** Participants will:

- Find out about the national picture for mental disorder for young people in your country
- Find out if there are any policy guidelines for working with mental health in your country

For this activity, you are asked to find out some demographic information about the extent of diagnoses of mental disorders in your country. Find out the total number of people who are diagnosed as having a mental disorder and the number of adolescents who are diagnosed as having a mental disorder. Are there any particular categories used? What was the source of your information? How easy or difficult was it to find out this information?

We are also asking you to find out if there are any nationally agreed clinical guidelines on dealing with children and young people who have a particular diagnosis. In Scotland, for example, the *Scottish Intercollegiate Guidelines Network (SIGN)* gives evidence based interventions for many kinds of medical diagnosis including psychiatric diagnoses. One example of a SIGN guideline is the guidelines on Attention Deficit Hyperactivity Disorder or Hyper Kinetic Disorder (ADHD/HKD) Have a look at the guideline. The link is given below. Is there an equivalent national guideline in your country? Take some notes on this activity and write them over the page

<http://www.sign.ac.uk/pdf/sign112.pdf>

### **Notes on activity two**

### **Activity 3: Defining mental disorder**

**Objectives :** Participants will

- Explore some definitions of mental disorder
- Decide on a helpful inter-professional definition
- Examine any differences or similarities between professional groups

We have already established that many of the young people with whom practitioners on the borderline work, have many aspects in common across the services. They tend to come from similar social backgrounds and they tend to have had disrupted early lives, at one level or another. So why are some labelled as having 'mental disorders' while others may not be? We will now begin to explore how psychiatry sees mental disorder.

Before we start, we should explain about what psychiatry is. Psychiatry is the medical speciality devoted to the study, diagnosis, treatment, and prevention of mental disorders. Psychiatrists are medically trained doctors. This is not to be confused with clinical psychologists who assess, diagnose, treat, and study behaviour and mental processes. Psychiatrists can use surgical and drug interventions while psychologists cannot do this. Psychologists would tend to use 'talking therapies' such as counseling or behaviour therapy to improve the symptoms of mental disorder. Psychiatrists can do this too. Mental health nurses are also medically trained.

Now we will look at how mental disorders have been defined over the years

Consider the following definitions of mental disorder.

***Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, mental retardation and disorders due to drug abuse. Most of these disorders can be successfully treated.***

World Health Organisation definition(2013)

[http://www.who.int/topics/mental\\_disorders/en/](http://www.who.int/topics/mental_disorders/en/)

***Insanity is a perfectly rational response to an insane world***

Quote from RD Laing (psychiatrist) in the Guardian newspaper (1/9/2012)

***Contexts, that is to say social, political, and cultural realities, should be central to our understanding of madness. A context centred approach acknowledges the importance of empirical knowledge in understanding the effects of social factors on individual experience (p726)***

Bracken, P. and Thomas, P. (2001) Postpsychiatry: a new direction for mental health. British Medical Journal, 322:724-727.

What are the underlying messages in each of the definitions? How helpful are any of them as functional definitions? Now think of your own definition of mental disorder which would be most helpful when working with young people.

**My definition of mental disorder:**

#### **Activity 4: Categorising mental disorders**

**Objectives:** Participants will:

- Look at the categories of mental disorder
- Discuss the usefulness of categorisation

There has been a great deal of controversy surrounding the definitions and usefulness of the terms 'mental illness' or 'mental disorder' and the categories within this. Anyone who receives a diagnosis today still

remains largely in the province of psychiatry, and hence are usually discussed in medical terms. Psychiatry categorises mental disorders in several different ways. There are two main medical classifications of mental disorders. One is the DSM 5 which is the American classification and the other is the ICD 10 which is the International Classification of Diseases from the World Health Organisation and which is the most commonly used in Europe.

### **1) Organic and Functional Disorders**

Organic disorders are caused by physical problems in the brain. For example, Alzheimer's disease is caused by the build up of protein plaques in the brain. This causes the brain to stop working properly.

Functional disorders mean that the disorder is mainly categorised by behaviour or how it affects functioning. There may be no apparent organic cause. Most mental disorders are classed as functional.

### **2) Neurotic and Psychotic Disorders**

Broadly, there are two main types of mental disorders for diagnostic purposes

#### **a) Neuroses**

The neuroses can be regarded as severe forms of normal experiences. A person affected by such a disorder may be in a great deal of distress but will not lose touch with reality. Examples of neurotic disorders include anxiety and depression.

#### **b) Psychoses**

The psychoses involve a distortion of a person's perception of reality, often accompanied by delusions and/or hallucinations. Examples of psychotic disorders include manic depression and schizophrenia.

However, not all diagnoses can be classified as either a neurosis or a psychosis. The diagnosis of 'personality disorder' falls outside these categories. In other diagnoses, such as 'post-traumatic stress disorder', there may be an overlap between so-called neurotic and psychotic symptoms. Finally, the term 'severe mental health problems' is sometimes used to refer only to the psychoses. However, people with severe depression or anxiety attacks can be just as disabled by their distress, as those with psychotic symptoms.

More information can be obtained from the chapter entitled *Classification of psychiatric disorders* at

<http://www.rcpsych.ac.uk/files/samplechapter/fishchapter.pdf>

A complete list of all mental and behavioural disorders is given in The ICD-10 (International Classification of Diseases Tenth Revision). This is the classification of mental and behavioural disorders published by the World Health Organisation.

Some details of the ICD classification are

- Organic mental disorders e.g. Alzheimer's disease, delirium
- Mental and behavioural disorders due to psychoactive substance use eg alcohol, street drugs, medications
- Schizophrenia, schizotypal and delusional disorders eg paranoid schizophrenia, psychotic disorders
- Mood [affective] disorders eg depression, manic depression
- Neurotic, stress-related and somatoform disorders eg anxiety disorders, obsessive-compulsive disorders
- Behavioural syndromes associated with physiological disturbances and physical factors eg eating disorders, non-organic sleep disorders
- Disorders of adult personality and behaviour eg paranoid personality disorder, transsexualism
- Mental retardation ie learning disabilities
- Disorders of psychological development eg specific reading disorders such as dyslexia, childhood autism
- Behavioural and emotional disorders, with onset usually occurring in childhood and adolescence eg attention deficit hyperactivity disorder, conduct disorders
- Unspecified mental disorders.

Having looked briefly at the diagnostic categories, work on your own for the next five minutes. Look at the following case study and decide which diagnosis may be given to this young person. Give your reasons for the diagnosis:

Peter is a 15 year old boy who is currently living with a foster family. He was initially taken onto care when he was 5 years old, when his parents were murdered. He consistently refused to attend school until he went to his foster family 5 years ago. Since then school attendance has been fine, although he still presents challenges to his teacher by being non-compliant in some learning tasks. He has a history of being violent and aggressive, especially toward females. He has been using cannabis for 3 years. Recently, he has been self harming by eating broken pieces of plastic which leads to hospitalisation. His foster parents are extremely concerned about him as they have found drawings he has done which depict gruesome death scenes. In a recent Facebook post, he spoke about hanging himself.

### **Activity 5: Exploring the medical and the social model of mental disorder**

**Objectives:** Participants will:

- Critically examine the medical model of mental disorder
- Critically examine the social model of mental disorder
- Explore notions of labelling, stigma and normality

Participants should read the following extracts about the medical model and the social model. After this, think about the positive and negative aspects of both models for the work you do with young people who are in distress.

#### ***The Medical Model***

The Medical Model

This is the most influential approach in psychiatry. This approach grew out of the discovery that mental illness could have a physical cause. For example, one of the most serious mental illnesses in past centuries was general paresis (syphilis of the brain). This caused paralysis and insanity and resulted in death within 2 - 5 years. Medical research eventually demonstrated that this was sexually transmitted and caused

by a bacterial infection which is now curable by antibiotics. Finding a reason and cure for some mental disorders marked huge progress for the medical profession and hopes were raised that an organic/physical cause would be found for every mental disorder.

Physical causes for mental disorders can include:

- Biochemical
- Physiological (related to whole body function)
- Anatomical
- Endocrinological (concerning the glands which secrete hormones)
- Genetic (includes predisposing factors concerning biochemical and physiological make-up and also disorders that have been inherited at birth)
- Environmental (external events that create psychological stress to such an extent that normal coping mechanisms are inadequate).

The medical model suggests that if the cause (aetiology) of the disease is physical then the cure needs to concentrate on the physical and not the psychological symptoms.

Treatments include:

- Drugs (eg tranquillisers, anti-depressants, antipsychotics etc.)
- ECT (electro-convulsive therapy)
- Psychosurgery (eg Lobotomy)

Physical explanations are sought for mental disorders and resources are channelled into the search for cures. The focus is on the individual patient as the problem.

### ***The Social Model of mental disorder***

Some commentators and service users argue that mental disorders are social constructs and that they can never be value free. The term 'mental illness' often provokes a negative reaction from people. As a society, we do not really want mentally ill people. Attitudes and structures in society tend to exclude those with a diagnosis from the mainstream. From the point of view of the social model, the main problem is not the person, but the structures and norms of society.

The social model draws on the work of anti-psychiatry (which you looked at in your self study), and the ideas of stigma and labelling. Young people who have a diagnosis of a mental disorder are particularly vulnerable to negative constructions of their identity because of the stigma surrounding mental illness, and by virtue of the



process of 'labelling'. In sociological terms, labelling theory was first advanced by Becker (1963) in his discussions of deviance. Labelling theory proposes that society creates both formal and informal sets of rules and rituals, which people must adhere to in order to be accepted as members of that society. These rules can include subtle expectations which can strongly influence specific aspects of behaviour that might be thought of as personal and individual, such as the way an individual chooses to dress. Differences, or deviancy in one aspect of behaviour can result in negative labels being attached to those who do not conform to these expectations or 'rules'. For a young person with a diagnosis, the individual personality and particular issues of the young person may be subsumed under what Becker would refer to as the master label of their psychiatric status. From this perspective young people with a diagnosis of a mental disorder are particularly prone to being seen as mainly as victims of their illness, which can lead to the desire to want to do something to them, or to 'fix' them. Such a process may lead those professionals who work with such young people to disregard their individuality, the positive aspects of their character and personality, and perhaps to ignore or underestimate the contribution which young people can make.

From the point of view of participation, young people with a diagnosis of mental disorder should be viewed as actors who can determine their own lives in the present. This point is important for any practitioners, because unless the practitioner goes beyond the 'symptoms' and respects the young person's strengths and abilities, any degree of participation is likely to be, at best, tokenistic and at worst, meaningless.

So in conclusion, the social model holds that it is society's attitude which disables the young person. They become labelled as 'mentally ill' and bear the stigma of being less than a complete 'normal' human being. Labelling and stigma leads to others acting towards them in a different way to which they would act if the young person did not have a diagnosis. What is needed is a conceptual shift away from seeing children with a diagnosis as problems for others, to a perspective which recognises they may be a minority group oppressed because their behaviour does not fit the norms of society. This model asks us to focus on aspects of mental illness which are structural such as gender, race and poverty inequalities in those with a diagnosis.

### **Question**

Which model guides the activities of which group of professionals, if any?

### Activity 6: Reflection

**Objectives :** Participants will

- Write a critical reflection on how their learning in sections one and two of this handbook may help them to understand a very challenging young person with whom they work
- Write out an anonymous case study based on one of the most challenging adolescents with whom they have worked. The case study should be based on the following template. It is important that you complete this as it will be used on your next face-to-face day. **BRING THIS TO YOUR NEXT FACE-TO-FACE DAY**

<b>CASE STUDY PART ONE</b>	
Anonymous name	
Age, gender, ethnic origin	
History and reasons for contact with social and health services	
What are the behaviours that make the young person so challenging for you?	

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Write a critical reflection about how some of the learning in sections one and two of this handbook may help you to work with this young person. In your reflection you should try to identify one piece of possible inter-professional practice which may be of benefit. You may want to use the headings below:

**Description**

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

**Action plan for future collaborative practice**

***Section three: Approaches to residential group care***

***This section is mandatory for mental health professionals and optional for residential staff/social pedagogues***

### ***About this section***

Group care practice for children and young people has existed for many centuries and in many different forms throughout the world. As practice has developed and global sources of knowledge and skills become available, a more analytical way of examining what works in group care is emerging.

There seems to be a political consensus at a global level that group care for children and young people should be seen as a last resort. However, this is to deny the benefits of good group care. It also devalues any positive experiences that children and young people may have in group care settings. For some young people, group care will be the best and only option. Good group care should be viewed as one option along a continuum of care, truly matched to the needs of the individual child.

In this section, some of the key concepts which are contributing to this emerging knowledge base will be explored. The life of the group and its potential to become a healing and nurturing environment for young people will be discussed.

The **objectives** of this section are:

- To learn about the historic development of group care
- To outline the key ideas of social pedagogy
- To outline the key concepts from child and youth care
- To provide opportunities to critically appraise the concepts in relation to group care

### **Activity One: What's the history?**

#### **Objectives**

Participants will

- Find out how residential care developed in their country
- Reflect on some of the changes in their country

Carry out a small piece of research about the history of institutional care of children in your country. Use the following questions to guide you and note your answers:

1. What did the institutional care of children look like in the late 19<sup>th</sup> century and up until the 1960s? Can you find any pictures or computer images of what older institutions looked like? How many children and staff were involved?
2. Did it change after that time? If yes, what were the changes? What do you think caused the changes?
3. What is modern institutional care like? Can you find pictures or computer images of institutions now?
4. How were the staff perceived in older times?
5. Who ran the institutions in the earlier part of last century? The state? Charities or NGOs? The church? Private businesses? Who runs them now? Have there been changes and if so why?

## **Activity two: Critical appraisals**

### **Objectives**

Participants will

- Read some of the literature on residential care and social pedagogy

- Critically appraise the papers
  - Reflect on different approaches to group care for children
1. First of all, read the following two papers about life in children's homes. Use the critical appraisal tool in Appendix one to give some comments about each of the papers

***Paper One: Life in children's homes***

[http://www.ncb.org.uk/media/521050/ncercc\\_lifeinchildrenshomes\\_crdr\\_eport.pdf](http://www.ncb.org.uk/media/521050/ncercc_lifeinchildrenshomes_crdr_eport.pdf)

***Paper Two: The Last Resort***

[http://www.savethechildren.org.uk/sites/default/files/docs/POLicy\\_Brief\\_Institutional\\_Care\\_2009\\_FINALrevbb4\\_08\\_%282%29\\_1.pdf](http://www.savethechildren.org.uk/sites/default/files/docs/POLicy_Brief_Institutional_Care_2009_FINALrevbb4_08_%282%29_1.pdf)

Note your critical appraisals over the page. Keep in mind that you should read the papers critically !! Who is writing? Why are they writing?

**Critical appraisal: paper one**

## **Critical appraisal: paper two**

### **Activity 3: Social pedagogy**

**Objectives:** Participants will:

- Examine some of the key concepts and debates in social pedagogy
- Reflect upon how such practice may impact on the mental health and wellbeing of the young person

Social pedagogy is a wide concept which is in common use in Europe. It is often called 'the continental tradition' and underpins direct work with children and young people in group care. It has a unique theory and



philosophical base and the work of the pedagogue is guided by the principles of 'head, heart and hands.'

**Head** represents the theoretical, philosophical and knowledge base of social pedagogy. Social pedagogues should know and understand the theoretical basis of their work. However, in addition, social pedagogues must always relate their knowledge to practice through reflection.

**Heart** is the attitude and stance you take to your work . Social pedagogues work in a way where appropriate sharing of their personal experiences, and empathy with the young person are central to their responses and their building of a healing relationship with the young person.

**Hands** is the practical application of skills, using head and heart. The social pedagogue enters into the group life of the young person, taking ownership for learning, highlighting positives and being authentic at all times.

Think about these concepts. Are they common across professional disciplines? What makes social pedagogy distinctive?

Now read the following paper

The following has been adapted from a full length article by Smith, M. K. (2009) 'Social pedagogy' in the encyclopaedia of informal education, [<http://infed.org/mobi/social-pedagogy-the-development-of-theory-and-practice/> Retrieved: 29<sup>th</sup> July, 2013]

'The term social pedagogy has been used to describe a range of work straddling social work and education....Social pedagogy (sozial pädagogik) has its roots in German progressive education – and is sometimes translated as 'community education' or 'education for sociality'. Here we explore its history and current status.

The term 'social pedagogy' has been used in countries such as Germany, Holland and Hungary to embrace the activities of youth workers, residential or day care workers (with children or adults), work with offenders, and play and occupational therapists. It has also been used to describe aspects of church work and some community development activity. In a few European countries the notion of animation is utilized to cover a similar arena of practice. With the growth of more integrated children's services in Britain, there has been an interest in social pedagogy as a means of making sense of the professional development of staff in these areas of state service.

As an idea sozial pädagogik first started being used around the middle of the nineteenth century in Germany as a way of describing alternatives to the dominant models of schooling. However, by the

second half of the twentieth century social pedagogy became increasingly associated with social work and notions of social education in a number of European countries. Within the traditions that emerged there has been a concern with the well-being or happiness of the person, and with what might be described as a holistic and educational approach.

Some of its practitioners translate it as 'community education' others in more social work terms – for example around care. It can be seen as having three key pillars or traditions. A concern with:

- The nature of man and, in particular the extent to which individuals can only develop fully as part of society. Within this tradition of social pedagogy there is an emphasis upon social integration and socialization.
- Social conditions and social problems. This tradition of social pedagogy found expression in the work of the university and social settlements in Britain and North America and in the development of social work. Eriksson, and Markström (2003) talk about this as 'the American tradition' and by this they are really focusing on social work. Within this element of the tradition there is an emphasis upon working with individuals, casework and providing care. In others there is more of an interest in and lessening the impact of inequalities in society, and dealing with social problems.
- Pedagogy – this tradition of social pedagogy has its roots in the work of educational thinkers and philosophers like Jean-Jacques Rousseau, Johann Heinrich Pestalozzi and John Dewey.

There are various debates about the nature of social pedagogy...As a starter it may be helpful to bear in mind the following elements. It is:

- A form of pedagogy and as such is rooted in education
- Holistic in character – there is concern with head, heart and hand.
- Concerned with fostering sociality
- Based in relationship and care.
- Oriented around group and associational life

The history of social pedagogy highlights a number of issues and questions. Here though we want to focus on three areas:

- Social pedagogy as a domesticating ideology.
- The pedagogue as an alternative way of constructing a professional... identity;

- The problem of pedagogy

### ***Social pedagogy – domesticating or emancipatory?***

Lorenz poses a question of lasting significance:

Is social pedagogy essentially the embodiment of dominant societal interests which regard all educational projects, schools, kindergarten or adult education, as a way of taking its values to all sections of the population and of exercising more effective social control; or is social pedagogy the critical conscience of pedagogy, the thorn in the flesh of official agenda, an emancipatory programme for self-directed learning processes inside and outside the education system geared towards the transformation of society? (Lorenz 1994: 93)

The basic issue here is whether the vision of community or society entailed is pluralistic and democratic, or narrow and totalitarian (or even elitist). The former is concerned with education so that all may share in a common life (as Dewey put it); the latter with advantaging a particular group. When social pedagogy becomes detached from democratic pluralism it can quickly deteriorate into a pernicious form.

### ***Professional identity – the pedagogue as an alternative paradigm***

In the German and Danish traditions, there is the readiness of significant numbers of workers to describe themselves as pedagogues. Social pedagogy defines the task and the process of all 'social activity' from theoretical positions beyond any distinct institutional setting and instrumental interest, and thereby safeguards the autonomy of the profession and appeals to the reflective and communicative abilities of the worker as the key to competence.

Just how autonomous practitioners can be within state-funded agencies is a matter of some debate – especially where they are in settings that are dominated by contrasting or antagonistic ideologies. However, Lorenz does have a point. The taking of the notion of 'pedagogy' into the way in which you name yourself makes a direct appeal to a particular body of theory and practice – and a particular paradigm.

It is this paradigm – especially the holistic view of the child that runs through social pedagogy, and the pedagogy tradition that can be found in Denmark – that has appealed to a number of commentators trying to make sense of developing the children's workforce in Britain. In Scotland in particular, there has been a significant discussion around the introduction of a 'new profession' – the Scottish pedagogue. This

profession could embrace the activities of classroom assistants, residential care workers, family support workers, family and children centre workers, youth workers and so on. Some commentators in Scotland have argued that pedagogy should be the central basis for workforce reform.

Rather oddly, very little attention in this has been given to the approaches and understandings already generated within the Scottish tradition of community education and community learning and development. Perhaps one of the reasons for this has been the readiness on the part of proponents to abandon the notion of the 'social' in the interest of using the pedagogue paradigm to embrace a wide range of existing occupational groups. Even where the 'social' is retained within recent British discussion however, a rather narrow appreciation has been dominant. This has largely been the result of the location of the debate within the largely individualistic and deficit frameworks of contemporary social work and social care. What all of this loses is an orientation toward a pedagogy for sociality - one that involves engagement with associational life, civic society, and local social systems.

### ***The problem of pedagogy***

A further set of issues and complications arises from the the usage of the term 'pedagogy' to describe the process. Here three particular issues arise. First, there is the problem of at whom the process is aimed. Etymologically, pedagogy is derived from the Greek paidagogue meaning literally, 'to lead the child'. In common usage it is often to describe the principles and practice of teaching children. Much of the work that 'social pedagogy' has been used to describe has been with children and young people. While writers like Paulo Freire (1972) have used the notion of pedagogy to refer to working with adults, there are others who argue that it is inextricably linked to teaching children.

Second, there are questions around the extent to which the notion of pedagogy has been formed by the context in which it is predominantly sited – the school. When we use the term are we importing assumptions and practices that we may not intend? Discussion of pedagogy is invariably linked to notions such as curriculum, instruction and subject. As such it may well be useful for thinking about aspects of what informal educators and amateurs do, but is much less helpful for exploring conversational and convivial forms of practice.

Third, and linked to the above, there is the danger of the 'pedagogization' or 'schooling' of everyday life. 'When we participate in the language of an institution, whether as speakers, listeners, writers, or

readers, we become positioned by that language; in that moment of assent, myriad relationships of power, authority, status are implied and reaffirmed. At the heart of this language in contemporary society, there is a relentless commitment to instruction'. Our language use as workers, and the way in which we define space can act to constrain exploration and to subordinate people.'

Mark Smith

#### **Activity 4: Concepts from child and youth care**

**Objectives** : Participants will

- Learn about some of the concepts from child and youth care
- Think about how it applies to group care of children

Read the following paper on working in the life space. This will introduce you to some concepts in child and youth care.

#### **Working in the lifespace**

One of the most useful models to emerge in the child and youth care tradition in recent years which has been helpful in understanding life in institutional settings has been that of lifespace. Lifespace work is neither individual casework nor group work, nor even individual casework conducted in a group context but is a therapeutic model of its own.

Within an institution, life space is the deliberate and focused attempt to promote individual growth and development within the context of daily events. There are certain key concepts within lifespace work. These are as follows:

- Milieu

The milieu is the environment and the setting. However, it is more than that, as it also encompasses the feel of the institution which is created from the interactions within it and what everyone brings with them into the space. Everything that happens in the institution has an effect on the lifespace, and the skill is in using this consciously to foster growth and development.

- Boundary and structures; Consistency v Flexibility

Staff working in institutions have an opportunity both to combine practical tasks and personal relationships with young people in a way that provides for good therapeutic work. However, many workers struggle to understand the balance between rules and boundaries and the flexibility required to meet each child's needs.

Rules and boundaries protect workers from their anxieties and their own underlying dynamics and serve to 'hold' children and young people emotionally. Many children in institutions may never have experienced boundaries and rules. However, flexibility is also required to ensure that the structure can accommodate the developmental needs of each individual young person.

- Rhythms and rituals

Rhythm is the process through which practitioner and young person find a common and comfortable way of being together. Rhythm is less rigid or prescribed than the kind of routine that might emerge from procedural attempts to impose order. The idea of 'just being' with the young person in a comfortable way is central to this.

Rituals are those practices that become embedded in the fabric of an institution and which have a significance and special meaning to the practitioners and young people who engage in them. Examples of the kind of rituals that can develop between practitioners and young people might be behaviours like having a pizza every Friday. At an individual level, it may also mean particular ways and sequences of settling at bedtime. These may be very individual for each young person and may carry a particular significance and sense of meaning. An appreciation by the practitioner of such seemingly mundane aspects of everyday life speak of connections and a sense of care toward the young people with whom they work.

- Assessment and involvement in activities

Working in the lifespace involves ongoing assessment of the emotional, physical and cognitive abilities of the young people in the selection of daily activities and the way they are undertaken. The worker should weave the activities into the fabric of the milieu, taking into account the needs, interests and limitations of the worker and the resources available to them. Healthy independence can only grow out of preceding experiences of dependency needs having been recognised and met.

- Use of self and relationships

A key area of working in the lifespace is the use of self in relationships with young people and managing the impact of this. You may have seen this in the article by Thom Garfat which you read in preparation for today. The practitioner needs self management in the face of constant exposure to residents, often competing in each others' presence for a practitioner's time and attention.

- Working with defences

In working in the lifespace, the defences and emotions of the young people are part of the mix along with the defences and emotions of the practitioners. Staff who work with young people have been attracted to a profession where they can only ever partially succeed.

This is sometimes called "the self-assigned impossible task". This leads to a need to manage the inherent anxiety in the complex tasks of the helping profession.

- Therapeutic containment

The concept of therapeutic containment offers a way of understanding the needs of children, and the needs of staff for that matter, that can ground the work in residential child care and give it a beneficial focus.

The concept of containment was introduced by Bion . He described the importance of the parent or primary care giver hearing the infant's distressed cries and responding with nourishment, a nappy change, holding, or whatever was needed—but most importantly, a response that is soothing and provides comfort. Essentially, the parent 'takes away' the unbearable, or uncontainable, and replaces it with something manageable. Eventually the child internalises this ability to manage pain and uncertainty. This ability is so fundamental that it is often taken for granted, yet it is vitally necessary for human development. Unfortunately, many children and their families face difficult

circumstances and experience significant disruptions to these early processes of containment.

Many of the young people who come to the attention of our services have not had 'good enough' experiences of containment. Therefore when negative feelings arise, they can be more intense due to the pain of 'unsoothed', unresolved feelings that also get triggered—similar to the pain of prodding an infected wound that hasn't healed properly. Much of the work of residential child care is to provide therapeutic containment for children, helping them to develop the ability to better manage their experiences and emotions. While practitioners might not explicitly draw from containment theory, the idea of teaching children to 'talk it out' rather than 'act it out' will be familiar and resonates on a basic level with the work of containment.

- Self awareness

When working with young people one of the aims is to help them make sense of themselves and their lives. This developing self-awareness comes from learning in the group and through individual work with their key workers, all taking place within a context of meaningful relationships.

- Meaning making

The process of meaning-making is central to the process of intervention in child and youth care perspectives. Attending to and understanding our own process as well as that of the young people with whom we work helps us to understand our responses to one another. In understanding the process, we create the opportunity for different interpretations and, therefore, different responses to one another.

One of the characteristics of effective interventions with young people is that interventions are intentional, created to serve a specific purpose in the interaction between helper and the young person. Attending to the process of meaning-making, allows us to act in an intentional manner, and to interpret the actions of young people in a personal, as well as professional context. We make meaning from moment to moment, depending on the circumstances within which we have the experience.

The above extract was adapted from the paper entitled *Working in the Lifespace* by Mark Smith, a chapter of the Online publication '**In Residence**'

[<http://www.celcis.org/media/resources/publications/A12.pdf> accessed on 21st July 2013 ] and the paper entitled *Therapeutic Containment and Physical Restraint in Residential Child Care* by Laura Steckley from the online publication **Good Enough Caring** [<http://www.goodenoughcaring.com/Journal/Article110.htm> accessed



Now make some notes on the similarities and differences between the Child and Youth Care Perspective and the Social Pedagogy Perspective. How has this set of readings affected your understandings of how a staff member can work with a young person in a residential group care setting?

### **Activity 5: Practice applications**

**Objectives :** Participants will

- Reflect on the feelings of staff who become child care practitioners
- Explore how some of the concepts learned during this section are apparent in the case

You should now read the following case study. This is a true story written by a child and youth care practitioner. After reading the case study, think about how the children and young people discussed reflect your own experiences across disciplines. How do the concepts from social pedagogy or CYC perspectives enter into the story? How would your service deal with some of the dilemmas thrown up by the young people in the case study?

#### ***Case study***

My first job was in a secure care unit for adolescents, which allowed for the confinement of young people. Children in the unit were often quite emotionally disturbed and violent. The combination of these two elements, in addition to locks on every door and window to prevent children going outdoors, was challenging.

Enter Darren. Darren was the most violent and distressed child that I have worked with in my career. I was to complete a behavioural/social assessment and make recommendations as to a placement which would be appropriate for him at the end of his "locked" period.

Over the course of the next five months Darren ran the gamut of behaviour, from running away from our "secure" unit, physically assaulting staff, and punching the walls till the blood flowed from his hands, to being a wonderful, fun-loving child who sought out affection

from the staff and contributed actively. I vowed to be the one that didn't give up, the one professional that didn't desert this lonely boy.

The recommendations I made represented many months of first hand exploration with Darren. None of them were acted on. Darren was moved into another region where he knew no one. I was discouraged by his social worker from staying in contact with him. I soon learned the reality of the child welfare system, as well as how it hinders the therapeutic nature of child and youth care. Darren did not receive the care that he needed; he had never been able to form a meaningful and lasting bond with someone, nor did he receive the unconditional love he yearned for. I came to understand that the therapeutic nature of child and youth care has to exist primarily in the here and now. It was through Darren that I began to understand that child and youth care is who I am, it is not just what I do.

My next professional experience can be summed up in one word: Kenny. Kenny was nine years old and his mother and father had both died in a car accident. He had been placed in our receiving and assessment home until an appropriate placement could be found. The "system" immediately took over, deciding that he should have no contact with his older sister and should not be allowed to attend his parents' funeral. Kenny was the first younger child that I worked with and his innocence about life and his need for a different level of caring was immediately apparent. Much time was spent reading bedtime stories to Kenny, helping him wash his hands and face at night, and running bubble baths for him. The flip side of caring for Kenny was exhausting and troubling. Over the next three months he was physically restrained at least once everyday. On some days the staff would be "holding" him for a greater part of the eight hour shift. Our professionally designed case plans, intervention plans, behaviour management plans, etc., were useless, leaving us with an immense feeling of being unable to properly meet this child's emotional needs.

I could write a novel about the lessons that I learned from Kenny. He taught me how afraid we are to deal with loss, how we wrongly expect behaviourally oriented plans to deal with the root of our humanness: our emotions. He also taught me how resourceful we become when we need to have our physical and emotional needs met. You see, I know that Kenny did not need to be restrained physically every day. What he did need, which he got, was someone to hold him and spend time with him while he grieved. Unfortunately for Kenny, few of us had an understanding of what it meant to provide therapeutic caring for children and adolescents in their lifespaces.

My work with Kenny also heightened my awareness of the true value of child and youth care. The psychological assessment of Kenny was completed by a psychologist who spent two hours administering psychological tests. From those two hours came a report which made statements about the "functioning level" of this young man. They pegged him as emotionally disturbed, attention seeking, lacking in self-

esteem, and so on. When I read the report I began to realise the critical nature of my work in the lifespace. I was the one who ate with him; I was the one who played games with him; I was the one who held him; I was the one who read him stories at night. Yet the psychologist had all the power to affect this child's life. It was somewhere in the midst of this realisation that I made the decision to be a true therapeutic caregiver; I made the decision to understand the child or youth, not as a "case" to be solved, but as a human being who needed some human understanding and support to overcome the barriers that lay before him or her. I began to see the children and youth I worked with as possessing power, and we could be their partners in healing.

Enter Heather. She was a young lady who had lived most of her pre- and early adolescence on the street, selling her body as a means to survive and belong. Heather had been described in all previous reports as "emotionally disturbed," and "displaying inappropriate sexual behaviour," . Heather and I quickly developed a relationship and spent long hours just talking as two human beings, rather than as professional and client. We discussed the various sexual acts that she had been forced to perform in her job as a prostitute; we discussed the money that was paid to her; and we discussed the physical and mental abuse she received from her pimp. All this was done with little or no emotion displayed by Heather.

Heather met Matt through our programme. The attraction was instant and Matt asked her out for a date. She was excited but we all assumed that this sort of thing would be "old hat" to Heather given her past occupation. The day after the date Heather came into my office and closed the door. She look at me sheepishly, blushing and avoiding eye contact, and then said in an innocent, child-like voice: "He kissed me." I hugged her.

When I look at what I have just written, I realize that it is only through this process of exchanging experiences in the lifespace that I have come to an understanding of whom I have truly learned from: the children and young people. They are the ones who have fostered my growth; they are what being a therapeutic caregiver is all about. They helped me to value myself as a practitioner.

### Activity 6: Reflection

**Objectives :** Participants will

- Write a critical reflection on how their learning in sections one and three of this handbook may help them to understand a very challenging young person with whom they work
- Write out an anonymous case study based on one of the most challenging adolescents with whom they have worked. The case study should be based on the following template. It is important that you complete this as it will be used on your next face-to-face day. **BRING THIS TO YOUR NEXT FACE-TO-FACE DAY**

<b>CASE STUDY PART ONE</b>	
Anonymous name	
Age, gender, ethnic origin	
History and reasons for contact with social and health services	
What are the behaviours that make the young person so challenging for you?	

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Write a critical reflection about how some of the learning in sections one and three of this handbook may help you to work with this young person. In your reflection you should try to identify one piece of possible inter-professional practice which may be of benefit. You may want to use the headings below:

**Description**

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

## **APPENDIX ONE: Critical appraisal tool**

### **(1) INTRODUCTION**

If the paper has an introduction or an abstract, what are the aims of this paper ?

### **(2) CONTEXT**

What type of paper is this? Is it a research paper, a summary, a report, a review or something else?

What geographical and health/care setting is the paper addressing?  
Over what time period is the paper addressed? How recently was the paper published?

### **(3) ANALYSIS**

Give a brief outline of the summary or recommendations of the paper. What are its key aims? What data collection methods or sources of information were used in the paper? How wide or selective were the sources? How well is the analysis laid out? Are arguments clear? Is there clear evidence for any statements made? Are recommendations or conclusions valid and reliable given the information collection?

If it is a research paper, is the research methods adequately described? How were the data analysed? How adequate is the description of the data analysis? Are the findings interpreted within the context of other studies and theory? What was the researcher's role? Are the researcher's own position, assumptions and possible biases outlined?

What are your own views about the paper? What have you learned and what could be clearer? Have you any unanswered questions as a result of reading the paper? What could have been done better?

### **(4) POLICY AND PRACTICE IMPLICATIONS**

Implications: To what setting are the paper's findings generalisable? To what population are the paper's findings generalisable? Is the conclusion justified given the analysis and the information gathered? What are the implications for policy? What are the implications for service practice?

## **Evaluation form**

**Module One: Part three - Self study and e-learning**

**Can you please provide some comments on the following:**

<b>The handbook for self study and e-learning</b>	
<b>The methods used (reading, critical appraisal, online platform, websites and links)</b>	
<b>Did you need any tutor support during this part of the course? If yes, what did you need and why?</b>	
<b>Content of the handbook</b>	

<b>Guidance for activities</b>	
<b>Guidance on what you had to do for your portfolio</b>	

***Module two***

***Problems that practitioners face in everyday work***

***Part two: Introduction to approaches to work practices in residential child care and in psychiatric services***

***Self- study and e-learning (a)***





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### ***Introduction***

Welcome to this handbook. It contains information and instructions on how to complete your first self study / e-learning day for Module Two. For this part of the module you will be working independently and you will need to be able to access information from the internet and from the online platform. As you progress through the handbook, you will be guided on what you should incorporate into your portfolio. To remind you, the objectives of the module are

- To explore contextual issues which affect practice including images of childhood, working with families and culturally sensitive practice
- To reflect on some of the key problems which affect the young people with whom we work including trauma, loss, separation, substance misuse and self-harm
- To develop case work examples from real practice
- To further identify the challenges and benefits of multi-professional collaboration on the borderline

On your face-to-face day, you worked on part of objective 1 and also on part of objective 3. For this self study day, you will complete your work on objective one and continue with some work on objective 3 which addresses your case study. You will also be extending your knowledge of international perspectives. You will be getting to know more about some of the problems facing practitioners in other countries.

### **Activity One: The international view**

Access the online platform and look at the following material which has been left by each of the countries:

- The guidance for new mental health or residential practitioners on images of childhood
- Suggestions for inter-professional work with parents / carers

Think about what has been written. What similarities and differences exist between countries and between your country and other countries? Take a note of these on the next page and add this page to you portfolio.

**Reflections on similarities and differences between countries on  
The guidance for new practitioners and suggestions for better  
inter-professional work with parents.**

**Activity Two: Understanding family functioning-genograms**

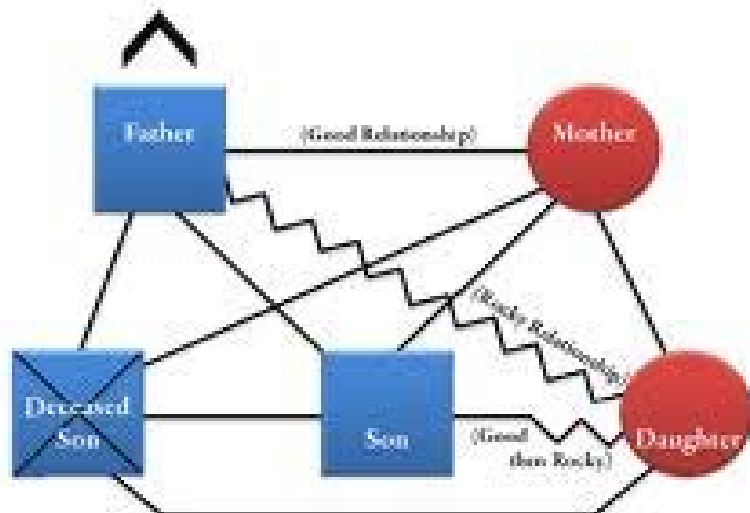
**Objectives :** Participants will

- Explore how to construct a genogram
- Construct a genogram for the young person in their case study

A genogram is a pictorial display of a person's family relationships. It goes beyond a traditional family tree by allowing the family and their worker to visualise hereditary patterns and psychological factors affect relationships. It can be used to identify repetitive patterns of behaviour and issues that repeat in families.

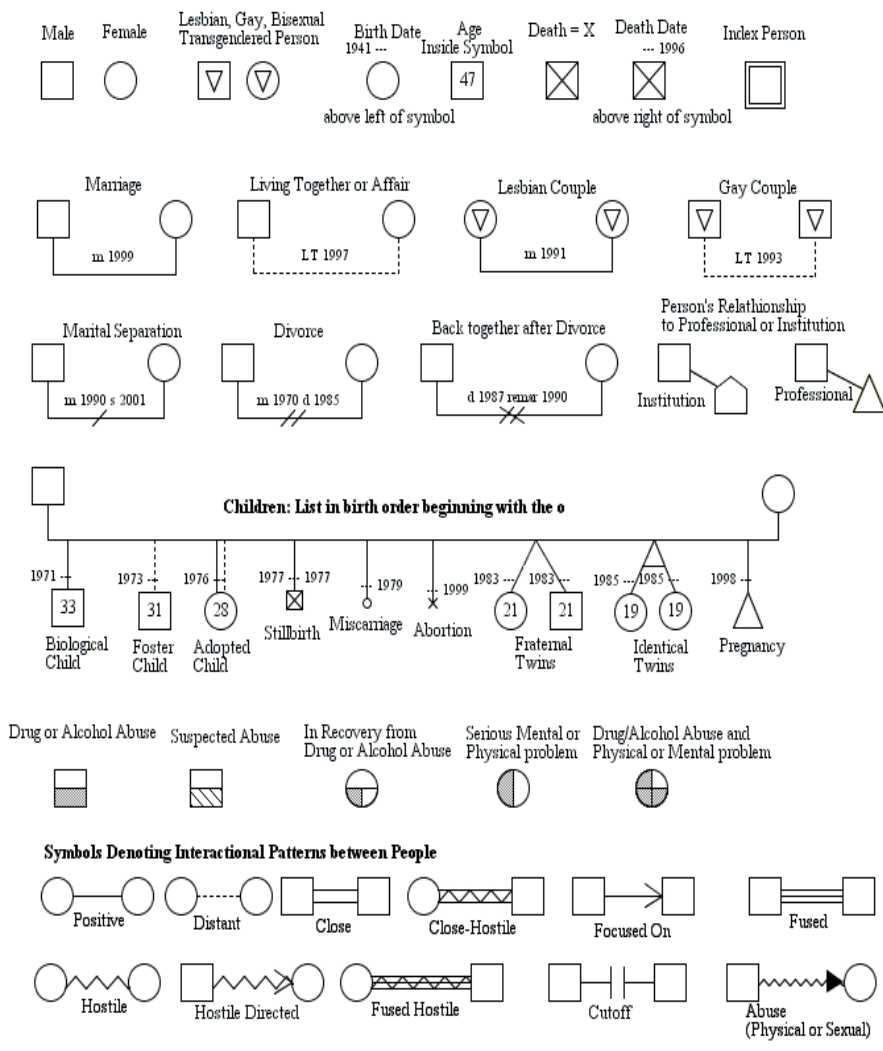
Genograms can be used by health professionals and residential child care staff to help the family to understand the roots of its functioning. The following is an example of a genogram

### Example Genogram



Here are the typical symbols used when constructing a genogram

**Standard Symbols for Genograms**



**Having looked at the symbols for a genogram and the typical structure, make out a genogram for yourself and your family on the following page. Then complete a genogram for the young person in your case study.**

**My genogram**



<b>CASE STUDY PART FOUR: GENOGRAM</b>	
Anonymous name	

### **Activity Three: The demographic picture**

**Objectives :** Participants will

- Examine some of the demographic information for their country
- Begin to reflect on diversity and cultural issues

For this activity, you will be asked to find out some of the figures relating to work with culturally diverse groups.

- a) Do you work with any families or young people from a minority group? (Race, ethnicity, religion, sexuality)
- b) In your locality, what are the main minority groups?
- c) In your country, find out the numbers of the main ethnic, racial, religious and sexual preference groups.

Write a short note of your findings below:

### Activity Four: A model of cultural competence

**Objectives** : Participants will

- Explore what is meant by cultural competence
- Examine their own level of cultural competence

Read the following article. When you have finished, complete the cultural competence self- assessment in Appendix One

#### ***Building cultural competence***

One of the models which looks at building cultural competence is Mason's 5 stage model

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5
Cultural destructiveness	Incapacity	Cultural blindness	Pre-competence	Competence

1. Cultural destructiveness: This represents attitudes, policies, structures and practices within an organisation that are destructive to a cultural group. Examples include: forced assimilation, subjugation, segregation and apartheid.
2. Cultural incapacity: This is the lack of capacity of organisations to respond effectively to the needs, interests and preferences of culturally diverse groups. Characteristics include: institutional or systemic bias; discrimination in hiring or promotion; disproportionate allocation of resources that may benefit one cultural group over another; messages that some cultural groups are neither valued nor welcomed.
3. Cultural blindness: This expresses the philosophy of viewing and treating all people as the same. The traditional helping approach is viewed as universally applicable to everyone: 'one size fits all'. Characteristics include: services ignore cultural strengths, little value placed on training that assist cultural competence, workforce lacks diversity, few structures and resources dedicated to acquiring cultural knowledge.
4. Cultural pre-competence: This shows a level of awareness within organisations of their strengths and areas for improvement to respond successfully to diverse service users. Characteristics include: hiring practices that support a diverse workforce; having the capacity to conduct needs assessments in diverse

communities; effort made to improve service delivery for specific cultural groups; tendency for token representation on committee or advisory group.

5. Cultural competence: This demonstrates organisations commitment to and respect for cultural differences. Characteristics include: creating a mission statement with principles for cultural competence in all aspects of the organisation; implementing policies and procedures that integrate cultural competence in each core function of the organisation; developing structures and strategies to ensure community participation in planning, delivery and evaluation of the organisation; implementing policies and procedures to recruit diverse workforce; providing support for professional development.

Cultural competence requires that professionals:

- Have a defined set of values and principles and demonstrate behaviours, attitudes, policies and structures that enable them to work effectively cross-culturally.
- Demonstrate the capacity to (a) value diversity, (b) conduct self-assessment, (c) manage the dynamics of difference, (d) acquire and institutionalise cultural knowledge and (e) adapt to diversity and the cultural contexts of the communities they serve.

Now complete this quiz to assess some of your knowledge of working in a culturally competent way.

### **The culture quiz**

**Purpose:**

To test your current knowledge of cultural competence with this true/false quiz. It helps you to reflect on your own knowledge and experience about working with culturally diverse people.

### **INSTRUCTIONS**

This quiz takes about fifteen minutes - there are 12 multiple choice and true/false questions.

1. Cross-cultural misunderstandings between service providers and clients can lead to mistrust and frustration, but are unlikely to have an impact on objectively measured clinical outcomes.

True

False

2. When the client and provider come from different cultural backgrounds, the medical history obtained may not be accurate.

True

False

3. A conscientious health or social care provider can eliminate his or her prejudices or negative assumptions about certain types of service users.

True

False

4. When taking a case history from a patient or client with a limited ability to speak your country's language, which of the following is LEAST useful?

a. Asking questions that require the patient to give a simple "yes" or "no" answer, such as "Do you have trouble breathing?" or "Did you come here within the past year?"

b. Encouraging the person to give a description of her/his situation,

and beliefs about their problems and issues.

c. Asking the patient whether he or she would like to have a qualified interpreter for the visit.

d. Asking the person questions such as “How has your condition changed over the past two days?” or “What things make your social situation worse?”

5. When a young person is not adhering to their intervention plan, which of the following approaches is NOT likely to lead to adherence?

a. Involving family members.

b. Repeating the instructions very loudly and several times to emphasise the importance of the treatment.

c. Agreeing to a compromise in the timing of the intervention.

d. Spending time listening to discussions of cultural interventions or remedies

6. Which of the following are the correct ways to communicate with a person through an interpreter?

a. Making eye contact with the interpreter when you are speaking, then looking at the person while the interpreter is telling the person what you said.

b. Speaking slowly, pausing between words.

c. Asking the interpreter to further explain the person’s statement in order to get a more complete picture of their situation.

d. None of the above.

7. If a family member speaks your country’s language as well as the young person’s language, and is willing to act as interpreter, this is the best possible solution to the

problem of interpreting.

True

False

8. Which of the following statements is TRUE?

- a. People who speak the same language have the same culture.
- b. The people living on the African continent share the main features of African culture.
- c. Cultural background, diet, religious, and health practices, as well as language, can differ widely within a given country or part of a country.
- d. An alert provider can usually predict a person's behaviours by knowing what country s/he comes from.

9. Some symbols—a positive nod of the head, a pointing finger, a “thumbs-up” sign—are universal and can help bridge the language gap.

True

False

10. Which of the following is NOT TRUE of an organisation that values cultural competence?

- a. The organisation employs or has access to professional interpreters that speak all or at least most of the languages of its clients.
- b. The organisation posts signs in different languages and has information materials in different languages.
- c. The organisation tries to hire staff that mirror the cultural diversity of its clients.
- d. The organisation assumes that health or social care staff do not need to be reminded to treat all patients or clients with respect.

The answers are in Appendix One.

Our own approach to work and our values can determine how culturally sensitive we are in our work. Go to APPENDIX TWO and complete the self-assessment quiz. Reflect on what this tells you about your approach.

Now look at APPENDIX THREE. This checklist outlines some things you may do with a person from a minority group. Does this happen in your organisation? Is your organisation well prepared to work with anyone from a minority group? If not, what does it require to do to improve?

**Activity five: Case study of Sammy**



Read the following case study. What are the issues for you professional group? What do you do? What are the inter-professional issues? Note the thoughts and dilemmas and we will discuss them at the next meeting.

Sammy is 15. He has been in your service since he arrived in your country two years ago. He is Somalian and came to your country as an unaccompanied asylum seeker. His village was destroyed during the civil war in Somalia and the majority of his family killed. He went with a brother to a refugee camp and the remaining family pooled their wealth to pay for Sammy to come here. He was picked up by social services in the capital city shortly after arrival. The gang that had brought him in to this country were offering him as a male prostitute. For his own safety, he was placed in residential child care.

When he came here, Sammy would not speak, exhibited obsessional behaviour over simple routines (such as eating or washing) and hid for long periods in a cupboard in his room. After three weeks he was assessed by the adolescent psychiatric services and placed for a month in a private clinic specialising in dealing with adolescent post traumatic stress. This resulted in a dramatic improvement, enabling Sammy to return to a residential child care unit.

Sammy has been doing extremely well and seems a resilient young man. He has learnt your language, is expected to do well at school and hopes to go on to University. He is proud of his African roots and wants eventually to return home as a doctor, lawyer or similar professional. He still has flashbacks and when under stress, behaves compulsively but this is managed by a combination of sensitive support from staff and input from mental health services.

Staff have been helping Sammy maintain his cultural roots. With the assistance of a local organisation, Refugee Aid, a family of asylum seekers from a neighbouring village was identified and has befriended Sammy. He visits the family most Sundays, which has become a very special day. An important aspect of the contact is that the family is the only one in the city that uses Sammy's local dialect – which is important to him as a cultural link.

After his most recent visit Sammy was talking with a member of staff, who had asked him what he did on the visits. He said that 15 years old is a significant age in his culture, the threshold of manhood. On the last two visits he has been invited to join the men after the communal meal. They sit in a room, story telling, and smoking a communal hookah

which contains a form of cannabis. This is the norm in Sammy's culture and an important rite of passage for boys to be accepted into manhood. Sammy says it would be insulting (and difficult) to refuse. He also said that it stops his flashbacks, helping him to feel relaxed and untroubled.

Apart from Sammy's disclosure, there are no physical or mental manifestations to suggest substance misuse. He is not part of any alcohol or drug use in his current place of residence and does not smoke.

### **Activity six: Youth culture**

Watch the YOUTUBE clip at the following link:

<http://www.youtube.com/watch?v=qIPD-GII2HI>

The clip discusses youth culture. No matter what young person you work with, you have to understand their youth and peer group culture. Watch the clip and reflect upon how the identity of youth represented in youth culture can create issues or conflicts. How can you alter your practice to take this into account?

### **Activity seven: Culturally sensitive practice**

Watch the presentation on culturally sensitive child care practice at the following link

[http://www.youtube.com/watch?v=Bw\\_9z\\_m6EFQ](http://www.youtube.com/watch?v=Bw_9z_m6EFQ)

As you watch, take a note of the TEN points that the author proposes to help culturally competent child care. Put the ten points into your own context. Do you do this in your practice? If you do, give an example of how you do this. If you don't, keep a note and we can discuss this at the next meeting.

### **Activity eight: Reflection and evaluation**

- Write a critical reflection of their learning on culturally sensitive practice
- Complete an evaluation form for the day to provide feedback on how the handbook contributed to learning

Write a critical reflection on your learning on culturally sensitive practice using the guidance overleaf

Write a short reflective log about what you have learned about culturally sensitive practice. Think about any part of the learning within this handbook which caused you to stop and think, and about how the learning may impact on your inter-professional practice in the future. Put this into your portfolio.

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

**Action plan for future practice**

**APPENDIX ONE : QUIZ ANSWERS**

**1. Cross-cultural misunderstandings between providers and clients can lead to mistrust and frustration, but are unlikely to have an impact on objectively measured clinical outcomes.**

**False:** Low levels of cultural competence can impede the process of making an accurate assessment or diagnosis, and reduce their adherence to recommended treatment or interventions

**2. When the client and provider come from different cultural backgrounds, the history obtained may not be accurate.**

**True:** Because of language and cultural barriers, the patient may not understand the questions or may be reluctant to report symptoms or

problems; in turn, the provider may misunderstand the patient's description of the issues.

**3. A really conscientious health provider can eliminate his or her own prejudices or negative assumptions about certain types of patients.**

**False:** Most of us harbour some assumptions about patients, based on race, ethnicity, culture, age, social and language skills, educational and economic status, gender, sexual orientation, disability/ability, and a host of other characteristics. These assumptions are often unconscious and so deeply rooted that even when an individual person behaves contrary to the assumptions, the provider views this as the exception to the rule. A conscientious provider will not allow prejudices to interfere with making an accurate assessment and designing an appropriate intervention plan.

**4. When taking a medical history from a patient with a limited ability to speak your country's language, which of the following is LEAST useful?**

**Answer: a.** While it may seem easier to ask questions that require a simple "yes" or "no" answer, this technique seriously limits the ability of the person to communicate information that may be essential for an accurate history. The most effective way to put the person at ease and to ensure that the person provides essential information about his or her situation is to combine two types of questions:

1) open-ended questions such as "Tell me about the pain in your knee" and 2) more directed questions, such as "What makes the pain get better or worse?" Always get a qualified interpreter when possible.

**5. When a person is not adhering to a prescribed intervention plan, which of the following approaches is NOT likely to lead to adherence?**

**Answer: b.** Non-adherence can be the result of many different factors that may require a variety of interventions. Simply repeating the instructions may not address the real issues that are keeping the person from adhering to the plan. Family members can provide valuable support. It may also be necessary to set small, realistic goals in order to achieve long-term behavioural change. Finally, an understanding of the person's beliefs about other remedies/interventions may offer valuable clues to her/his reluctance to adhere to the plan.

**7. Which of the following are the correct ways to communicate with a person through an interpreter?**

**Answer: d.** Although it may seem natural to look at the interpreter when you are speaking, you want the person to feel that you are

speaking to her/him, so you should look directly at her/him, just as you would if you were able to speak her/his language.

**8. If a family member speaks your country's language as well as the young person's main language, and is willing to act as interpreter, this is the best possible solution to the problem of interpreting.**

**False:** This is an inappropriate responsibility for families to take. The rationale for using professional interpreters is clear. Professional interpreters have been trained to provide accurate, sensitive two-way communication and uncover areas of uncertainty or discomfort. Family members are often too emotionally involved to tell the young person's story fully and objectively or lack the technical knowledge to convey the message accurately.

**9. Which of the following statements is TRUE?**

**Answer: c.** The only assured similarity among people from around the world who come to you for care is the fact that they are your clients and they hope to be treated with respect and with concern for their individual needs. As a practitioner, it is important to have a basic understanding of your young persons' cultures—

and to recognise the similarities and differences among people from the same region of the world and the same country. Differences in cultures within a region can be

pronounced. Each person is the product of many cultural forces. People from the same continent, the same country, the same part of the country, and even the same city, may have major differences in cultural heritage, traditions, and language, as well as differences in socioeconomic status, education, religion, and sexual orientation. It is the combination of all of these factors that make up a person's "culture."

**10. Some symbols—a positive nod of the head, a pointing finger, a "thumbs-up" sign—are universal and can help bridge the language gap.**

**False:** Each of these symbols has a very different meaning in different cultures and may be offensive.

**11. Which of the following is NOT TRUE of an organisation that values cultural**

**competence:**

**Answer: d.** Even the most conscientious, committed staff that have been trained in cultural competence may need periodic reminders. In a busy practice, it is easy for providers to seek shortcuts, slipping into assumptions about the culturally diverse they serve and failing to take the time needed to fully understand the beliefs and values of each client.

## APPENDIX TWO

### Cultural competence self-assessment checklist for practitioners

#### Purpose:

To increase the awareness of practitioners to the importance of cultural and linguistic competence in health and social care settings. It provides examples of the kinds of beliefs, attitudes, values and practices which foster cultural and linguistic competence at the individual or practitioner level.

#### INSTRUCTIONS

Please select **A**, **B** or **C** for each item listed below.

A = things I do frequently

B = things I do occasionally

C = things I never do

Environment		
1	I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of individuals or families to whom I provide service.	
2	I ensure that brochures, magazines and other printed materials in reception areas are of interest to and reflect the cultural diversity of the community in which I serve.	
3	When using DVDs, films or other media resources for education, treatment or other interventions, I ensure that they	

	reflect the culture and ethnic backgrounds of individuals and families to whom I provide a service.	
4	I ensure the printed information I provide takes account of the literacy levels of individuals or families to whom I provide a service	
<b>Communication styles</b>		
6	When interacting with individuals and families who have a limited understanding of my national language, I always keep in mind that:  __ limitations in spoken language do not reflect in any way on their intellectual capability.  __ their limited ability to speak my language has no bearing on their ability to communicate in their own mother tongue.  I use bilingual staff trained in medical interpretation when required or requested.	
7	For speakers of other languages I try to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.	
8	I understand the cultural context for naming diseases and try to be respectful of this in my interactions. In some cultures there is stigma attached to terminal disease and sexually transmitted diseases.	
9	I can provide alternatives to written information if required.	



<b>Social interaction</b>		
<b>10</b>	I understand and accept that family is defined in a variety of different ways by different cultures (e.g., extended family members, kin, godparents).	
<b>11</b>	Even though my professional or moral point of view may differ, I accept individuals and families as the ultimate decision makers for services impacting their lives.	
<b>12</b>	I understand that age, sex and life cycle factors need to be considered in interactions with individuals and families. For instance, a high value may be placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family.	
<b>13</b>	I accept and respect that male-female gender roles may vary among different cultures and ethnic groups (e.g., which family member makes major decisions for the family).	
<b>Health, illness and end-of-life issues</b>		
<b>14</b>	I understand that the perception of health, wellness and preventive health and social services have different meanings to different cultural or ethnic groups.	
<b>15</b>	I recognise that the meaning or value of medical treatment and health education may vary greatly among cultures.	
<b>16</b>	I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death.	
<b>17</b>	I understand that grief and bereavement differ by culture.	

18	I seek information from individuals, families or other key informants  that will to respond to the needs and preferences of culturally  and ethnically diverse communities served by my organisation.	
19	I keep abreast of the major health or social care issues for culturally diverse groups living in the local area served by my  organisation.	
<b>Values and attitudes</b>		
20	I avoid imposing values that may conflict or be inconsistent with  those of cultures or ethnic groups other than my own.	
21	I screen books and other resources for cultural, ethnic or racial  stereotypes before sharing them with individuals and families  served by my agency.	
22	I intervene in an appropriate manner when I observe other staff  or service users within my agency engaging in behaviours that  show cultural insensitivity, racial biases and prejudice.	
23	I understand and accept the family is defined differently by  different cultures (e.g. extended family members, godparents).	
24	I am aware of the socioeconomic and environmental risk factors  that contribute to problems of culturally diverse groups served by my agency.	
25	I recognise that the meaning and value of medical treatment, social service intervention and education may vary greatly among cultures.	

26	I understand that the perception of health and wellbeing and have different meanings to different cultural groups.	
27	I accept that religion and other beliefs may influence how individuals and families respond to social interventions, illnesses, disease and death.	
28	I avail myself of professional development and training to enhance my knowledge and skills in the provision of services to cultural diverse groups.	
29	I advocate for the review of my organisation's mission statement, goals, policies and procedures to ensure that they incorporate practices that promote cultural and linguistic competence	

**PLEASE NOTE:**

There is no answer key with correct responses. However, if you frequently responded with "C," you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural competence in working ethnically diverse families and young people. If so, reflect on what you can do about this.

**APPENDIX THREE**

**CULTURALLY SENSITIVE HEALTH AND SOCIAL CARE CHECKLIST**

The following issues should be recorded when addressing the health and social care needs of patients/clients:

**NAMING:**

Preferred name/form of address

This may also be used to record name of significant relative(s) if, for example, the partner's name is different. Ask both the individual and partner for their official name and 'what you would like us to call you'.

**LANGUAGE:**

(spoken and written)

A selection of the most likely options should be offered.

**INTERPRETER NEED:**

This should be recorded along with the preferred gender of the interpreter.

**DIET OPTIONS:**

Key preferences will be suggested: some patients/clients will want the option to choose from the local menu as well as special diets from their country of origin.

**PRAYER OBSERVATION:**

Times and requirements (e.g. washing, privacy, prayer mat).

**Evaluation form**

**Module Two: Part two - Self study and e-learning**

**Can you please provide some comments on the following:**

<b>The handbook for self study and e-learning</b>	
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<b>The methods used (reading, critical appraisal, online platform, websites and links)</b>	
<b>Did you need any tutor support during this part of the course? If yes, what did you need and why?</b>	
<b>Content of the handbook</b>	
<b>Guidance for activities</b>	

<b>Guidance on what you had to do for your portfolio</b>	

***Module two***

***Problems that practitioners face in everyday work***

***Part three: Psychiatric and mental health problems***

***Face-to-face day 2***



***Contents***

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Activity four: Warm up after lunch

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Activity six: Plenary, evaluation and preparation for self-study / e-learning

Appendices

References

Evaluation form





### ***Introduction***

Welcome to this handbook. It contains information and instructions you will need to take part in the second face-to-face day for Module Two. For this part of the module you will be working with your group on part of the following objective:

- To reflect on some of the key problems which affect the young people with whom we work (i.e. trauma, loss, separation, substance misuse and self-harm)

This second face-to-face day consists of a series of activities which will help you to focus on understanding the needs of young people at risk. The handbook has been divided into activities with clear guidance on what objectives should be met at the end of each activity. At the end of the handbook, you will be guided on how to collect evidence for your portfolio.

Young people at risk can display behaviour that can seem frightening, hostile or self-destructive. Such behaviour will evoke powerful emotions and feelings in practitioners working on the borderlines. To be effective, all practitioners have to feel equipped and empowered when trying to understand and work with such behaviour. One helpful way to deal with such behaviour is to understand where it may be coming from.

We are aware that you are a professional staff member with a range of existing knowledge. Indeed you are probably a highly qualified individual ! So while the training covers some areas of knowledge which are necessary for all professionals working with at-risk children on the borderlines, the focus will be on your own thoughts, feelings and work experiences and also on learning from fellow practitioners from other work settings and other countries.



**Programme for face-to-face day**

- 9.00 –9.30:     Arrival, registration, ground rules and introductions
- 9.30 – 10.30:    The neurobiological basis of trauma and neglect
- 10.30 – 10.45:    Break
- 10.45 – 11.15:    Assessment and neurobiology
- 11.15 – 12.15:    Separation and loss
- 12.15 – 1.15:     Lunch
- 1.15 – 1.30:     Warm up and orientation
- 1.30 – 4.00:     Casework for international comparison
- 4.00 – 4.30:     Next steps

**Activity 1** : Arrival, registration and re-orientation

**Time to complete the activity:** 30 minutes

**Objectives** : Participants will

- Feel comfortable in the training



- Get an opportunity to have some fun
- Go over the ground rules for the day

Your tutor will lead you through an introductory activity. The key point is to ENJOY this !

Your tutor will also ask if you have brought your case study for further work today. You will also have the opportunity to give some feedback on the self-study / e-learning part of the course which you have undertaken prior to your face-to-face meeting today



## **Activity 2: The neurobiological basis of trauma and neglect**

**Time to complete the activity:** 90 mins

**Objectives :** Participants will

- Explore the effects of early trauma on the brain
- Examine and critique a method of assessment of need based on developmental trauma-based concepts

Your tutor will now show you a powerpoint presentation on some of the neurobiological effects of trauma. This is based on the work of Bruce Perry, a child psychiatrist. A copy of the powerpoint presentation is contained in Appendix One.

Now look at the following paper. This has been adapted from Nina Parsad's review of Perry's work. It outlines the 6 core strengths needed for positive development.

### **Perry's six core strengths**

Perry argues that there are six key strengths which need to be developed by children in order for them to be more resourceful, more successful in social situations and more resilient. In order for a child to gain a strong foundation for the future these six strengths need to develop sequentially and build upon each other to contribute to their emotional development. Each strength continues to be shaped over the life of the child.

#### **i. Attachment**

The brain is designed to encourage relationships. There are parts of the brain which specifically respond to emotional cues (such as touch and facial expressions) and these systems appear to be closely associated with the parts of the brain which experience pleasure. When a child starts to develop healthy attachments they get a degree of pleasure from them that is related to the intensity of that attachment. Thus a child gains more pleasure from pleasing their caregivers than a stranger. When a child is learning emotional, social and cognitive tasks the greatest reward they can receive from their caregiver or teacher are approval, attention and recognition of their success. As a child grows

they require a wide range of healthy relationships in order for their attachment capabilities to mature. When a child has a limited number of positive relationships in their lives or where they have experienced negative primary caregiving experiences the child is at risk of a range of challenges.

#### ii. Self-regulation

Self-regulation is the ability to identify and control primary urges such as hunger as well as feelings such as frustration. This core strength is directly related to a child's stress-response system. The brain is continuously sensing and responding to the body's needs. When something is wrong it will alert the stress-response system and act to help the body obtain what it needs. Most of the brain's regulation occurs automatically however as a child matures the brain requires that they participate in their own body's regulation .

When the stress-response system develops normally, humans are able to respond to complex, challenging situations with appropriate solutions. When a child's ability to self-regulate does not develop in a healthy way then they are at risk of behaviour problems and the inability to regulate primary urges. Children or young people who are poor at self-regulation become quite disruptive. They are more likely to be impulsive, hypersensitive to changes and tend to overreact to small stressors.

#### iii. Affiliation

The ability to affiliate allows humans to form and maintain relationships with others. Babies are born being dependent on their caregivers and as they grow older they need to form interdependent relationships with others in order to survive. Affiliation has its roots in attachment and then uses self-regulation to grow and thrive. While attachment begins with one-to-one relationships, the relationships humans develop in groups are more complex and require the capacity to regulate one's anxiety, impulsivity and frustration. It is the combination of the previous two strengths that allows a child to form and then regulate their relationships with others and thus develop the strength of affiliation.

Perry argues that the majority of children or young people who have problems within a group setting have not been able to develop the appropriate skills in affiliation and self-regulation. They struggle with identifying social cues and when they do not get what they want they act impulsively or immaturely. This then makes other children or young people avoid them thus creating a negative feedback cycle which results in the initial child or young person having fewer opportunities to socialise.

#### iv. Awareness or attunement

Attunement is the ability to read and respond to the communicated needs of another. Humans have to manage a constant stream of

sensory information. Some of the most complex forms of sensory information come from other humans. Spoken language, subtle gestures and non-verbal expressions all come into play when humans interact with each other. The ability to be aware or attuned to others is essential to human communication and successful interactions and relationships. As a child grows they become more aware of how complex other people are by watching and listening to others and forming friendships

When negotiating between relationships the brain uses a set of rules that makes the process easier. These rules are based on association and generalisation. Each sense can only receive and process one form of information at a time. When two or more senses receive information at the same time then the brain makes a connection or association between those sensations. By making associations the brain allows humans to make an accurate, internal representation of what is occurring in the world around them. It then incorporates the representation and stores it as memory. Memory allows humans to create a catalogue of relational experiences. A child's ability to self-regulate allows them to develop a healthy awareness of others and their ability to affiliate with a wide range of people allows them to build a diverse relational catalogue .

#### v. Tolerance

Tolerance is the capability of someone to accept differences in others. This strength emerges when a child has the security arising from the development of the previous four strengths (attachment, self-regulation, affiliation and awareness). According to Perry there are necessary components of developing tolerance. Firstly a child needs to feel that they are special, valued and accepted. This only occurs when the important people, mainly adults, in a child's life tells and shows them that they are special, important and loved. It is when a child feels accepted for themselves that they are able to accept others. The second component is related to how easily a child feels threatened by someone or new things. The brain categorises new things as dangerous unless proven otherwise. When a child who feels safe is introduced to a new person, idea or culture they will be excited by these things. A child who does not feel safe will in turn experience these same things as threatening. When a child struggles with this strength they will create an environment around themselves which fosters exclusion and intimidation of people and groups they fear. This type of atmosphere can promote violence .

#### vi. Respect

Respect requires emotional, social and cognitive maturity that only comes to a child once they have developed the previous five strengths. To develop the capacity to respect is a lifelong challenge. A person's sense of self across their life will vary according to the challenges they face. The development of self respect is guided by how a person sees

themselves and by how people in their lives respond to them. When a person gains attention and encouragement from the people that are important to them then they develop a positive image of themselves. Likewise, young children develop their sense of self-respect from their interactions with others. A child who is able to respect themselves, their own strengths and vulnerabilities, is more likely to be able to respect others.

Humans tend to respect people who have traits that they admire. Young children respect things they see in the adults in their lives. Thus a child will be heavily influenced by what they are exposed to in life by the adults in their lives. Perry felt there are two ways in which children may struggle with respect. Children could be overtly non-compliant or defiant. This behaviour is almost always associated with a poor sense of self. The second way in which a child struggles with respect is when they are self-deprecating. Children with such a poor sense of self will begin to limit their own opportunities.

(From Prasad, N.(2011). Using a neurodevelopmental lens when working with children who have experienced maltreatment. A Review of the literature of Bruce D.Perry. Accessed on 23<sup>rd</sup> August 2013 at [www.childrenyoungpeopleandfamilies.org.au/info/social\\_justice/submissions/research\\_papers\\_and\\_briefs/?a=62366](http://www.childrenyoungpeopleandfamilies.org.au/info/social_justice/submissions/research_papers_and_briefs/?a=62366) )

After the presentation and your reading, you should take a short break.

After your break, you will be re-examining your case studies in your inter-professional pairs.

In your pairs, have some discussion of the cases in the light of the presentation and your reading of Perry's strengths. You will have two tasks to complete

1. Continue with the case examination, using the template over the page to question and consult with each other and jointly agree on the outcomes of the young person's exposure to trauma and neglect
2. Jointly complete an assessment of need for each of your cases. Notes of issues to look for in assessment and a form to fill in

about the child are contained on the pages following the  
continuation of the case study overleaf.





<b>CASE STUDY PART FIVE</b>	
Anonymous name	
What types of trauma and neglect has the young person been exposed to, and at what ages?	
In your joint opinion, how has the young person's 6 core strengths been affected by the trauma and neglect?  1. Attachment 2. Self regulation 3. Affiliation 4. Awareness/Attunement 5. Tolerance 6. Respect	
How does this link to the behaviours that make the young person so challenging for you?	

### **Assessment of need**

Identifying the roots of trauma-related behaviour is often complex. It is important to recognise that there is no 'quick fix' or easy formulas that can be applied to provide the answer. One approach to understanding this is provided by Melzak (1997). Melzak stresses the importance of the child's personal, psychological and social experiences and offers nine concepts upon which to base a developmental trauma-based assessment of need. Using the form over the page, examine your group case study using the following concepts and questions:

*Developmental issues* – Do I know the early life history of the child? If not, how can I find out? What is the child's level of physical, cognitive, emotional and social development? What is the child's level of educational attainment in relation to other children in their community or institution? What is the child's ability to communicate their needs? Are there any health problems?

*Social factors* – What is the quality of relationships with parents/carers, siblings and peers? What is the child's experience of poverty/deprivation/racism and what are the links with the wider community? Is the child easily bored and inactive? Is the child confused - do they understand the demands and requests placed upon them?

*Loss and separation* – What are the losses and separations the child has experienced? How has the child been helped to cope with these, especially if they have entered an institution?

*Change and transition* – What are the changes in routine or life experience that the child has had in the recent past? What are the implications and effects of these changes? How does the child cope with transitions?

*Trauma* – What traumatic situations has the child experienced? How has the child coped and in particular how has s/he expressed her feelings and emotions? How might previous traumatic life events be having an impact on present behaviour? Do you know the 'triggers' that might provoke the child's behaviour?

*Violence* – What violence has the child experienced in the past? What was their role (ie victim/survivor, bystander, rescuer, perpetrator). When did this happen and how might it have affected their neurological development?

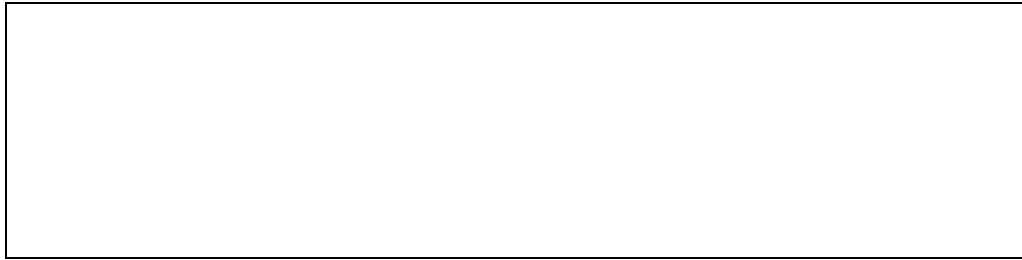
*Scapegoating* – What was the child’s position in relation to other family members. Do they have close relationships? Was s/he in a position of power or was he/she scapegoated? Is scapegoating related to anything in particular (eg race, gender, disability, sexuality, other ) ?

*Secrecy* – is there a level of secrecy surrounding the trauma, neglect, loss or separation experienced by the child? How might professionals address such secrecy?

*Culture* – How does the culture of the child mediate upon trauma, neglect, loss and separation? How does the culture of your organisation (Health agency or residential care setting) have an impact on dealing with trauma and its behavioural outcomes? Does it unconsciously contribute to trauma, neglect, separation and loss? What kind of support are professionals given to help them work with and absorb the pain of traumatised children?

<b>CASE STUDY PART SIX : ASSESSMENT OF NEED</b>
Developmental issues
Social factors
Loss and separation

Change and transition
Trauma
Violence
Scapegoating
Secrecy
Culture



### **Activity 3: The effects of loss and separation**

**Time to complete the activity:** 60 minutes

**Objectives:** Participants will

- Reflect on their own experiences of loss
  - To discuss how their personal experiences can be used to help the young people with whom they work
1. With your partner from another profession, identify from your own childhood or adolescence a person you lost or were separated from, and whom you have some positive memories of. Discuss the following questions with your partner :
- What positive memories do you have of the person?
  - What did you do to help yourself cope at that time?
  - What did other people do to support you at that time?
  - What emotions did you experience at the time?
  - How did this loss affect the way you manage loss now?
  - How can this experience help you in your work with at-risk young people?
  - How can this experience help you to work collaboratively with other professions?

Take notes of your thoughts about these questions for the feedback session. Once you have completed your pairs work, read the article on bereavement on the following pages. Then in the large group discuss how you apply your experiences to helping young people in borderline practice. Who should take on what roles and why?

### **Study notes on bereavement**

Bereavement is probably the most serious loss a person will experience. It has been described as 'a state that is characterised by loss' (Herbert, 1996, p. 246). Yet despite its ubiquity, it is something for which people are often completely unprepared. As adults, we talk very little about death and bereavement. Although it is a natural and inevitable part of life, death is often kept hidden away. Gatliffe, as cited in Mallon (1998) states that it is almost as though we have come to regard death as just another disease to be conquered. As a result it is often a 'taboo' subject, particularly around children.

Bereavement is a process which some children may have to go through and deal with. As a result, those who work with children should be aware of the emotional, social, personal and educational effects this may have on the bereaved child. So how do staff fulfil their role in meeting the individual needs of bereaved children?

To understand the place of death in children's lives, we need to look at the beliefs and behaviour of adults around them. The attitudes and values of our society influence what we believe and how we think; they provide a framework for ordering the things that happen to us, for defining our purpose and place in the world. Death is a biological fact. What it means for us and what we teach our children about it are the result of socially shaped ideas and assumptions. Bereavement has also been described as 'a wound which needs time to heal' (Yule & Williams, 1990, p. 267). Dying and death are not everyday topics of conversation; they are mostly regarded as morbid and best ignored and hence they are unfamiliar issues for many people. Talking about death can elicit embarrassment and defensive attitudes, perhaps because it is often associated with pain, fear, ugliness and hopelessness. Every year, thousands of children face bereavement, perhaps through death of a grandparent, parent, friend or sibling. In these cases, adults may be so deeply engrossed in their own grief that the feelings of the children involved may not be noticed. The losses of children and young people who come to the attention of social services can be profound. Children may develop particular problems and needs that must be acknowledged and tackled if they are not to suffer unduly, perhaps into adulthood.

#### *Children's perceptions of death*

Children's understanding of death develops in parallel with the child's cognitive maturing through childhood. The development of the concept of death may occur at slightly different rates, but the developmental sequences seem to be the same. For younger children around five to eight years old, it has been found that this is also the age of fear and fantasy. A child may personalise death as a skeleton, monster or ghost. From the age of nine to twelve, greater cognitive ability gives the child an awareness of the finality of death: that it is common to all living things and that it is final, universal and inevitable. From twelve through to adolescence, children are searching for identity and meaning in their life. It is at this stage where 'the child's concept of death becomes more abstract, and they are able to understand more of the long-term consequences of loss' (Dyregrov, 1991, p. 12). Adolescents are able to grieve more as adults do, with appropriate crying, and with feelings of sadness, anger and depression.

#### *Effects of bereavement on the child*

When a death or major loss occurs, a child will experience many different reactions and behaviours to cope with their grief. Grief is not expressed just in words; it is not answered just in words. Shock and disbelief are usually the child's first response to a death or major loss. A child's reaction may be a silent withdrawal or a wild outburst of screaming. A very young child cannot understand what is going on, but may be sensitive to an extremely disturbed, sad atmosphere in the home, and an upset of everything familiar to them. Dyregrov found that 'children may refuse to accept the death and firmly maintain this – thus keeping the painful fact at a distance' (1991, p. 13). Even though the child knows his or her loved one is dead, the child's every thought is so centred on that person that he or she cannot believe that the person is not around. The child has lost something and experiences a profound need to find that person again. The fact that they cannot find the person can lead to the child experiencing overwhelming fear, followed by despair. Anger is commonly expressed after a major loss, and this feeling may confuse bereaved children and young people. This anger may be directed at different entities. For example they may be angry at God for letting it happen, at adults because they exclude them from their grieving processes, or at themselves for not preventing the death. Another emotion that is common in a bereaved child is anxiety. 'Anxiety is an essentially adaptive emotion, in that it motivates us to initiate behaviours that prevent the anticipated harm being released' (Herbert, 1996, p. 271). One of the most common fears that children have is a sense of guilt, which may be associated with a specific aspect of the loss rather than a general sense of total self-blame.

In the case of at-risk children, it is important to remember that bereavement may be closely linked to their attachment style. The attachment style of a child is based on their early childhood experiences. Attachments can either be secure, insecure, anxious or avoidant. Secure attachments arise when a baby has a warm loving relationship with its main carer at an early age. The baby knows it can depend on its carer and grows up to have a secure attachment style. Children who have main carers who are unreceptive or over-anxious will have anxious or avoidant attachment styles. For example, Wayment and Vierthaler (2002) found that those who reported having a secure attachment to the deceased reported greater levels of grief. Individuals with an anxious attachment style reported greater levels of grief *and* depression. Higher levels of psychosomatic disorders were reported by those with an avoidant attachment style.

### **Understanding the grief process**

There are a number of ways in which the grief process can be conceptualised. The following is one of the best known models, based on the writings of Kubler-Ross (1969) and Murray-Parkes (1986). There is traditionally a five stage process to understanding grief.



## **Shock**

At the point when the loss happens, it may be difficult to acknowledge that the event has taken place. The emotional state may be numbness and an inability to register that anything serious has taken place.

## **Denial**

Eventually the state of shock gives way to one of denial. The person may deny the emotional consequences of the loss or may even in extreme cases deny that the loss has taken place. For example, family members may leave the absent person's favourite armchair vacant as though expecting the person to return. People may even report seeing or touching the absent person.

## **Sadness/depression**

After a time the reality of the major event or change begins to dawn. Memories of the departed person and lost relationship may remain compulsively in the back of a person's mind. At this stage people may be tearful and miserable and be unable to get on with their school, work or other areas of their life. There is a possibility of sinking into depression. This stage may go on for a long time, with the person doubting their ability to manage the changed circumstances. Sometimes when a death occurs, the individual may take on all the blame for the situation and manifest severe depression and perhaps self-hatred. Sometimes the same person will also express hatred for the dead person for making them feel so hateful. It is not uncommon for people to swing between blaming themselves and blaming the person who has died for making them blame themselves, or between depression and anger.

## **Anger**

Periods of sadness and depression may be interspersed with feelings of anger, often quite intense, directed at the person who has gone. Sometimes the period of depression is followed by a period of anger, sometimes the anger comes first. There is no fixed pattern for everybody. People will often move back and forward between stages. Anger may be particularly powerful if the loss is sudden and there has been no time to prepare for it. In such a situation there may well be unfinished business, things that one would like to have said to the lost person or issues that have not been resolved. Their sudden departure deprives the surviving person of the ability to communicate such thoughts or feelings directly to the person who has left. Anger is particularly likely when the loss of another is interpreted as being a rejection or abandonment. In this situation people find themselves destroying letters or photographs or other memorabilia of the departed person. In terms of the grieving process it is easy to see how an

individual can become stuck at the stage of anger and unable to move on to acceptance.

### **Acceptance**

Finally, however, there comes a gradual acceptance that the death has occurred and that it is final. There is nothing left now apart from memories. Though there will be memories of the lost relationship, these are no longer compulsive or overpowering. There has been a kind of letting go. Eventually it becomes possible to remember what is lost without enormous amounts of emotional pain, and if what is lost was good, to remember it with fondness and love. What has taken place is a process of acceptance and emotional burial.

**Activity 4:** Warm up after lunch

**Time to complete the activity:** 10 minutes

**Objectives :** Participants will

- Feel comfortable in the training
- Get an opportunity to have some fun and waken up

Just enjoy !

### **Activity 5: Casework for international comparison**

**Time to complete activity:** 2 hours and 45 minutes

#### **Objectives**

- To prepare the material will be lodged on the online platform for work by our international colleagues
- To prepare for our own individual work

This is the group's time to prepare the material needed for further study by international colleagues. During this time you will be expected to work in your inter-professional pairs.

Look at the cases you have been working on and at the assessments produced during your individual and joint work, from part one to part six of the case.

Each pair should now begin to devise a model of good practice for inter-professional work in at least one area of each of the young people's lives.

To develop the piece of good practice, you will be using the model that was briefly introduced during your orientation day. Your tutor will go over this with you briefly. Then, looking at your cases, discuss them and write your good inter-professional practice intervention for each of the young people, using the headings overleaf

#### ***A model for describing best multi-professional practice***



### A good inter-professional practice intervention

- Give the practice a brief descriptive name
- Specify the area of social and health sector the practice relates to
- Specify what type of action the practice consists of (Preventative action? Early support? Corrective action?)
- Describe the practice and its purpose in a few sentences

#### A. How will the practice be implemented

The practice is concisely and fluently described based on the following elements:

- Actors: describe all the actors involved and what kind of knowledge they have (e.g. mental health staff, residential workers, social workers, children, families ?)
- Resources: specify the resources that have to be mobilised when implementing the specific practice (e.g. tools, facilities, theoretical perspectives)
- Process: specify the different phases of the practice and describe the activity they require from the actors. (Activities by the young person might be a certain attitude, or a certain thing that they do. Activities by multi-professionals might be the mobilisation of different methods, norms, theories, experiences. Activities by families might be informal support)

#### B. How to evaluate the practice

Here you should specify what type of information you need to collect about the effectiveness and functionality of the practice. It might be:

- Professional judgement ( documents, experiences and perceptions generated during the implementation of the practice)
- User knowledge ( interviews or questionnaires completed by young people and their families)
- Any other knowledge or perspectives you can think of

Now the pairs should get back together as a group and discuss the types of inter-professional interventions proposed by each of the pairs. There are two items of case work which should now go on to the online platform from each group member:

- The six page case study of each young person
- The model of good practice proposed for the young person

The tutor will rejoin that group at 4.00 to take the material you have generated for uploading to the online platform.

**Activity 6:** Plenary and evaluation

**Time to complete the activity:** 30 minutes

**Objectives**

- To give participants an opportunity to feed back on what they felt about the module so far
- To complete evaluation form
- To clarify any questions about the next self-study / e-learning period which you will be completing on your own.
- To upload the case work onto the online platform

You will be asked for some views about how you found the module and you will fill in the evaluation form at the end of this handbook and give it to the tutor. Any questions you may have about the module may be asked now.

Your cases will be uploaded onto the online platform. You will be referring to the work of international colleagues during Module Three.

Your tutor will now go over the expectations and programme for your next period of self study and will give you the handbook you will use to compete Module Two.

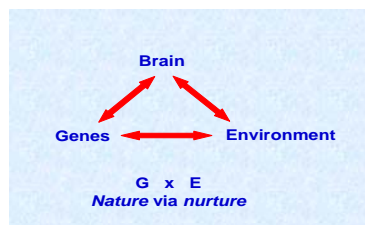
## APPENDIX ONE: COPY OF PRESENTATION AND NOTES

### SLIDE ONE

The effect of neglect and trauma  
on the developing brain of young  
people

Introduction: I hope you'll see by the end of the presentation the importance of nurturing in the developing brain

### SLIDE TWO



I'm going to start at a very basic level. Genes + environment affect how the brain develops. The brain is the seat of our emotions and actions. Nature and nurture interact. However, we now know that what happens when we are very young has a physical effect on our development.

### SLIDE THREE

Good child development needs:

- Good social environment
- Enriching relationships
- Appropriate, well-contained stress

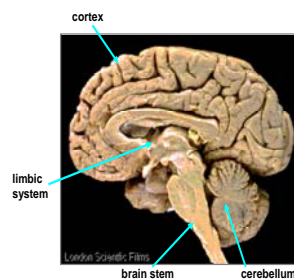


These are the things that are needed for healthy brain development



- Social environment: rich in attachments and connections to other people who are safe, warm and consistent
- Life experiences which give us the opportunity to make sense of the world
- Opportunity to have different kinds of experience in your life which contributes to your ability to handle stress

## SLIDE FOUR



There has been much recent research on brain development. The brain has ancient core (brain stem) which is overlaid by later, more complex layers. From the point of view of trauma, one of the most important of these is the limbic system : The limbic system contains a range of structures involved with regulation of the emotions, among other things.

Two main points about the limbic system

### POINT ONE

It stores memories of fearful events and the feelings associated with them. The association between feelings and the fearful events they predict can be triggered and lead to emotional responses which the rational brain will not understand. So for example, a smell can be associated with abuse. In other words, it stores the feelings and reactions associated with trauma

It stores these reactions because the limbic system of a traumatised child has been disrupted in its development. So the brain of a traumatised child is literally different from a non-traumatised child in that the limbic system is oversensitive to fear triggers

### POINT TWO

The limbic system is also responsible for our stress responses. In a normal stress response, the body is made ready for flight or fight. Once

this has been triggered, the body calms down again by flooding with a hormone called cortisol.

### SLIDE FIVE

*The stress-trauma continuum*

- Limbic system: picks up fear stimulation
- Triggers CORTISOL
- CORTISOL floods body acts to reduce fear in a feedback loop
- BUT not in the case of trauma as feedback mechanism fails

A red arrow points from the 'Triggers CORTISOL' bullet to the 'CORTISOL floods body acts...' bullet.

But if fear is around a lot, triggered by trauma then the feedback mechanism breaks down, and the body acquires a high level of cortisol at all times. This has the effect of making the person unable to tell between high and low threats. It is also indicated in depression and, more importantly, in dissociation. Like the Tom Hanks character in Saving Private Ryan.

### SLIDE SIX

*Effects of too much cortisol*

- Persistent hypervigilance
- Hypersensitivity

OR

- Dissociation

Because the feedback loop has broken down, the child will end up being hypervigilant, because they need to scan the environment for the possibility of others who may be dangerous, harmful and neglectful

They will also be hypersensitive, like a hair trigger waiting to go off at the least touch

OR

The trauma or neglect may have been so much that they completely shut down. This is called dissociation or freezing. The child goes to a safe place deep in their subconscious so that they can completely withdraw from the awful things that are happening in their lives. This can make them appear as if they are not paying any attention, are sullen or ignorant.

## SLIDE SEVEN

Stress-response system

Small to moderate amounts of stress experienced in predictable or patterned situations, help children develop brains that can help them deal with fear

However, if the stress is great, sudden, unpredictable, and/or threatening, it will be experienced as trauma with which young brains and minds cannot cope.

This slide explains itself

## SLIDE EIGHT

Controlling Children

- For traumatised children, hyperarousal and lack of ability to regulate their emotions leads to panic, impulsive behaviour and *fight-flight* responses. It makes children aggressive, impulsive, needy and frightened
- Under extreme trauma, a *freeze-dissociative* response is likely.

Bateman and Fonagy 2004

This slide explains itself

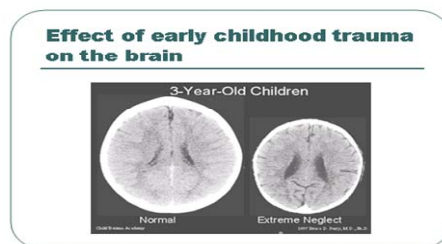
## SLIDE NINE

**“After reviewing the records of some 200 boys who were then living in the [Institutional] center or who had been in the past, I found that every single one of these boys – without exception - had experienced severe trauma or abuse.”**

Perry 2006

This is a quote from Bruce Perry who is one of the most influential researchers in the field of neurobiology. From his findings, we can assume that the majority of at-risk children will have been affected by trauma, neglect, loss or separation.

## SLIDE TEN



This slide based on Perry’s research speaks for itself. The CT scan on the left is an image from a healthy three year old with an average head size. The image on the right is from a three year old child suffering from severe neglect. This child's brain is significantly smaller than average and has abnormal development of cortex.

## SLIDE ELEVEN

How do we intervene?

1. Assess *DEVELOPMENTAL* age !!
2. Communicate at the *DEVELOPMENTAL* level of the child !!
3. Provide consistent, warm, nurturing environments and relationships for the child

Up until now, this may make us feel hopeless to intervene in the lives of damaged children. However, research also shows that we can intervene. On this slide are three key points of intervention.

Here's some things that any setting working with traumatised children should do:

Ensure the child has good diet and exercise

Talk to other colleagues, and form a relationship with the child which is healing and in which deep listening can occur

Remember that emotional habits take time to change but the child needs consistent repeated safe structured opportunities with another in a close relationship to help them to learn new habits. The child needs opportunities for emotional and physical holding.

Make sure that the child has their feelings recognised, acknowledged and tolerated by professionals in a consistent and nurturing way.

If professionals are intervening at the correct developmental age, you might be using interventions from the bottom of this list to help you to reach and heal a child who has suffered from neglect and trauma.

## SLIDE TWELVE

To summarise:

Caregivers and professionals must

1. Be psychologically available
2. Ensure the provision of physical care (food, warmth, hugs)
3. Be consistent in their relationship with the child



Caregivers and professionals must be

Psychologically available. In other words they must be there to listen and to hold the child and try to understand what the child is trying to communicate

Ensure provision of physical care because a highly traumatised young person may not understand words. They may be operating at a physical level, so love and care needs to be transmitted through physical means. That is, good wholesome food, warm clean living environments, caring adults around them who will comfort them by holding them when they are distressed

Consistent. In other words they are there for the child when they are needed and the child must learn that they will always provide the same responses of love and care within the relationship

These are pictures of babies on the slide. But this work in repairing the effects of trauma is important with older children. The slides are to remind us that we need to communicate at the DEVELOPMENTAL age of the child, and that a 15 year old aggressive boy might be functioning emotionally at the level of a baby !

## References

Dyregrov, A. (1991) *Grief in children: a handbook for adults*. London. Jessica Kingsley

Herbert, M. (1996) *Supporting Bereaved and Dying Children and Their Parents*. British Psychological Society, London

Kübler-Ross, E. (1969) *On Death and Dying*, London: Routledge

Mallon, B. (1998). *Helping children to manage loss*. London. Jessica Kingsley

Murray-Parkes, C. (1985) *Bereavement*. *British Journal of Psychiatry*, 146, 11–17.

Perry, B. D. (2001a). *Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood*. Houston: The Child Trauma Academy.

Perry, B. D. (2001b). *Keep the cool in school: Self-regulation – The second core strength*. *Early Childhood Today Magazine*. USA: Scholastic.

Perry, B. D. (2003). *The cost of caring: Secondary traumatic stress and the impact of working with high-risk children and families*. Houston: The Child Trauma Academy.

Perry, B. D. (2005). *Maltreatment and the developing child: How early childhood experience shapes child and culture*. Inaugural Lecture for The Margaret McCain Lecture Series. Canada: Centre for Children and Families in the Justice System.

Perry, B. D. (2009). *Six core personality strengths (in children and in adults)*.  
[www.recoveryroadmap.com/BigList/6CoreStrengths.html](http://www.recoveryroadmap.com/BigList/6CoreStrengths.html)  
[Accessed 19th February 2009].

Wayment, H.A., and Vierthaler, J. (2002). *Attachment style and bereavement reactions*. *Journal of Loss and Trauma*, 7: 129-149.

Yule, W. & Williams, R. (1990) *Post traumatic stress reactions in children*. *J. Trauma and Stress*, 3 (2, April), 279-295.

**Evaluation form**

**Face-to-face day two: Module two**

**Can you please provide some comments on the following:**

<b>The handbook</b>	
<b>The methods used (groupwork, tutor input etc)</b>	
<b>Tutor support</b>	
<b>Venue</b>	
<b>Content of the face-to-face day</b>	



<b>Standard of work expected</b>	
<b>Guidance on what you had to do for your portfolio</b>	

***Module two***

***Problems that practitioners face in everyday work***

***Part four: Psychiatric and mental health problems***

***Self study and e-learning(b)***



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Activity 2: Parental substance misuse

Activity 3: Substance misuse in young people

Activity 4: Some strategies to improve mental health

Activity 5: International work

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References

Evaluation form

## ***Introduction***

Welcome to this handbook. It contains information and instructions on how to complete Module two. For this module you will be working independently and you will need to be able to access the internet and the online platform.

During your self-study days you will be using the online platform to look at the work of other countries and also to complete the specific work of the objectives for this module. In particular, you will be looking at substance misuse and self-harm, as these have been identified as specific areas of challenge and interest across the borderline of practice with young people.

You will also be given the opportunity to reflect on inter-professional collaboration and to further identify the challenges and benefits of multi-professional collaboration on the borderline

As usual, the handbook has been divided into activities with clear guidance on what objectives should be met at the end of each activity. At the end of this handbook, you will be guided on what you should incorporate into your portfolio.

### **Activity 1: Self harm**

**Objectives** : Participants will

- Define what we mean by 'self harm'
- Reflect on our feelings about working with self harm
- Examine some of the ideas in relation to self harm and how to respond to this
- Identify experiences and knowledge of resources in working with self harm

Read the following paper which explores the issue of suicide and self-harm.

*Furnivall, J. (2013) Understanding suicide and self-harm amongst children in care and care leavers*

[www.iriss.org.uk/resources/understanding-suicide-and-self-harm-amongst-children-care-and-care-leavers](http://www.iriss.org.uk/resources/understanding-suicide-and-self-harm-amongst-children-care-and-care-leavers)

Using the template below, answer the following questions:

1. Think about some of the young people with whom you have worked who have self harmed or committed suicide. What has the extent of this self harm been? What were your feelings around working with self harm? How well prepared do you feel to work with this?



- cut yourself
- burn yourself
- bang your head or throw yourself against something hard
- punch yourself
- stick things in your body
- swallow things.

It can feel to other people that these things are done calmly and deliberately – almost cynically. But we know that someone who self-harms is usually in a state of high emotion, distress and unbearable inner turmoil. Some people plan it in advance, for others, it happens on the spur of the moment. Some people self-harm only once or twice, but others do it regularly - it can be hard to stop.

Some of us harm ourselves in less obvious, but still serious, ways. We may behave in ways that suggest we don't care whether we live or die – we may take drugs recklessly, have unsafe sex, or binge drink. Some people simply starve themselves.

### **Other words that are used to describe self-harm**

These terms were previously used to describe self-harm, but are now going out of use:

- **Deliberate self-harm (DSH):** the word 'deliberate' tended to blame people for their self-harm.
- **Suicide/Parasuicide:** these suggested that harming yourself is the same as wanting to kill yourself - which is often not the case.

### **How common is self-harm?**

- About 1 in 10 young people will self-harm at some point, but it can happen at any age.
- The research probably under-estimates how common self-harm is. It is usually based on surveys of people who go to hospital or their GP after harming themselves. However, we know that a lot of people do not seek help after self-harm. Some types of self-harm, like cutting, may be more secret and so less likely to be noticed.
- In a recent study of over 4000 self-harming adults in hospital, 80% had overdosed and around 15% had cut themselves. In the community, it is likely that cutting is a more common way of self-harming than taking an overdose.

### **Who self-harms?**

It happens more often in

- young women.
- prisoners, asylum seekers, and veterans of the armed forces
- gay, lesbian and bisexual people: this seems, at least in part, due to the stress of prejudice and discrimination
- a group of young people who self-harm together: having a friend who self-harms may increase your chances of doing it as well
- people who have experienced physical, emotional or sexual abuse during childhood.

### **What makes people self-harm?**

Research has shown that many people who harm themselves are struggling with intolerable distress or unbearable situations.

Common problems include:

- physical or sexual abuse
- feeling depressed
- feeling bad about yourself
- relationship problems with partners, friends, and family
- being unemployed, or having difficulties at work

You may be more likely to harm yourself if you feel:

- that people don't listen to you
- hopeless
- isolated, alone
- out of control
- powerless – it feels as though there's nothing you can do to change anything.

It's more likely to happen if you are using alcohol or drugs.

You may feel like harming yourself if you want to show someone else how distressed you are or to get back at them or to punish them. This is not common – most people suffer in silence and self-harm in private.

### **How does it make you feel?**

Self-harm can help you to feel in control, and reduce uncomfortable feelings of tension and distress. If you feel guilty, it can be a way of



punishing yourself and relieving your guilt. Either way, it can become a 'quick fix' for feeling bad.

<http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/self-harm.aspx>

## **Activity 2: Parental substance misuse**

**Objectives:** Participants will

- Reflect on the effect of parental substance misuse on young people
- Begin to explore how they can respond to this in their professional role
- Identify information on resources dealing with substance misuse

### ***Substance abuse***

Substance abuse is a growing feature of families who come to the attention of health and social service agencies. The use of any substance, whether it is drugs or alcohol, will impair the ability of

parents to be completely available for their children. It will have impacts on basic care and on attachment. In addition, long-term use of substances can lead to physical and mental health impairment. These can have an effect on the life span of parents, so it may be that health care professionals or residential child care staff will be working with parents or young people who have experienced bereavement and loss and who may be grieving for someone who has died. Depending on where the adult or child is, in terms of the stages of grief, will determine the adult's ability to parent well and the child's ability to respond to this.

### **Task**

Read the paper in Appendix One which addresses some of the issues in relation to substance misuse. Using the critical appraisal tool in Appendix Two, reflect on the paper. What does it mean for practice?

It would be helpful if you could note below, your experiences of working with young people affected by parental substance misuse and also to note how you have worked in collaboration with any other agency or professional on this area of the borderline

### **Activity 3: Substance misuse in young people**

**Objectives:** Participants will

- Reflect on substance misuse among the young people with whom they work
- Identify how they respond to this in their professional role
- Identify information on resources dealing with substance misuse

### **Factors in substance misuse**

Research shows that there are a range of individual and societal factors implicated in substance misuse. Some of these factors are outlined below:

1. Child abuse: Briere and Runtz (1993) demonstrated that abuse in childhood was linked to substance misuse in later life
2. Domestic violence: Raine (2001) showed that many women who have experienced domestic violence misuse substances to deal with the effects
3. Homelessness: Wincup, Buckland and Bayliss (2003) showed that homeless young people reported high lifetime, last year and last month prevalence rates for drug use (illegal drugs and illicit use of prescribed medication). Often they had begun experimenting with illegal drugs at a young age, typically aged 14
4. Poverty: Shaw, Egan and Gillespie (2007) in their comprehensive literature review, showed the clear links between poverty, deprivation and substance misuse.
5. Adolescence: Parker, Aldridge and Measham (1998) showed that substance misuse is likely to start in the teenage years. This is linked to aspects of adolescence such as peer pressure, curiosity and a rise in risk-taking behaviour. Among those young people not in employment or education, 71% claim to have used illegal drugs compared with 47% of young people generally
6. Looked-after children: Among other findings, Canning, Millward, Raj, and Warm (2004) reported that looked-after children are four times more likely to become involved in substance misuse than those who are not looked after
7. Mental health problems: Johnson (1997) reported a strong co-occurrence between substance misuse and mental health problems
8. Family breakdown: this is implicated in substance misuse. Barrett and Turner (2006) show that substance misuse is more highly associated with single-parent families

The list above is not exhaustive but gives some idea of the range of factors involved in substance misuse. While some experimentation with substances may be seen as 'normal' behaviour, there is a strong evidence base about the risk factors that can lead to problematic use. Sadly, the research also indicates that substance misuse is most damaging in the poorest communities.

## **Types of substances**

There are many types of substances which can lead to problematic substance use. Generally they can be divided into four broad areas

### **Uppers (or stimulants)**

What they do: - Stimulants act on the central nervous system, accelerating responses and depressing feelings of inhibition and tiredness. Blood pressure, heart rate and metabolic functions all increase – which can be fatal in the event of overdose. The effect is temporary and increased doses are required to achieve the same effects. Also, tolerance increases over time. For every action there is a reaction – the reactions to stimulants tend to be the opposite of the stimulant effect. Tiredness replaces energy, a feeling of being ‘wired’ or anxiety replaces confidence and paranoia replaces extravert behaviour. Not all effects are present with all stimulants and after effects vary according to the substances. Physical dependency can develop rapidly – continuing doses are required to prevent the onset of withdrawal system. The point is reached where continuing use is not for effect but to prevent withdrawal – i.e. you stop enjoying the drug and need it!

They include: - Tea, coffee, chocolate (chocolate contains caffeine, which is also the active stimulant in tea and coffee), cocaine, crack cocaine, amphetamines, tobacco (nicotine is the active stimulant) and ecstasy.

### **Downers (or depressants)**

What they do: - Depressants act on the central nervous system, slowing responses, reducing affect (i.e. lessening feelings, particularly those that are uncomfortable such as anxiety), ameliorating stress and giving a sense of comfort. Overdose severely impairs the functioning of the central nervous system and can result in death. Disinhibition, relaxation, well being and detachment from the world all occur to varying degrees with depressants. The effect is temporary and increasing doses are required to achieve the same effect. Tolerance increases over time. As the immediate effect wears off, tiredness tends to increase and feelings that were masked return. Alcohol in particular exaggerates feelings of depression for a day or two – long after any beneficial effects have worn off. As with stimulants, the point is reached where continuing use is not for effect but to prevent withdrawal

They include:- Alcohol, heroin, barbiturates, valium, temazepam, solvents and methadone

### **Mind expanders (or hallucinogens)**

What they do:- Hallucinogens effect brain functioning, changing perceptions of reality. This may be experienced as a heightened sense of awareness (such as colour, texture, sound etc.); hallucinations – seeing things that are not there (which can be pleasurable or frightening); and, delusions of reality (such as believing one can fly). More than one of these effects can be present and the boundaries between the effects can merge. For example, heightened awareness of sound can combine with a belief of being able to hear conversations in another room. The length of effect varies, typically the heightened state of awareness gradually wears off. Physical dependency does not develop but ‘flashbacks’ – or unwanted hallucinogenic episodes – can occur, in some recorded instances many years after original use. There is increasing evidence to indicate heavy regular use causes changes in brain function. Otherwise, any dependence tends to be psychological rather than physical.

They include:- LSD, magic mushrooms, cannabis, ecstasy.

### **Volatile Substances (solvents)**

What they do:- Many day to day household products contain gases or volatile substances that when inhaled effect the central nervous systems. They can affect the body in the same way as stimulants and hallucinogens; dependence and tolerance develop; and, there are withdrawal symptoms/psychological changes after use. The effect is short lived and use of volatile substances is dangerous. Active ingredients are highly concentrated and ingested very quickly – this can produce both shock and extreme highs.

They include:- Glue, lighter fuel, aerosols, deodorants, hairspray, cleaning fluids, shoe cleaners, paint thinners, nitrates etc.

Many drugs are used in combination with each other. This can be

- to heighten effects or
- because the drug of choice is not available or
- as 'self medication' to lessen the withdrawal or 'come down' from another drug
- for no particular reason other than a range of substances being available

Multiple drug use combines the 'best' and 'worst' features of the drugs used. For example, opiates are being used increasingly (either with or after) stimulants. Whilst in the short term the opiates alleviate withdrawal responses from stimulants, in the medium to long term the user experiences both sets of symptoms. Self medication of these effects, typically, results in stimulant use (at higher levels) to counter the opiates – then more opiates, and so on. Because of unpredictability and the combination of effects, multiple drug use is particularly dangerous. Death can occur when a combination of separate non-fatal doses of two drugs combines to produce a third or exaggerated reaction.

It might be helpful to know what substances look like. Go to the 'Know the Score' website at [www.knowthescore.info](http://www.knowthescore.info) Go to the Alphabetical 'find a drug' menu on the home screen. Hover the cursor over a letter and it will list all the drugs that begin with that letter in English. Click on the name of the drug and you will see pictures of what they look like and how they are taken. As a short exercise, look up the following drugs on the website and write out what they look like and how they are taken:

Heroin:

Ecstasy:

Cannabis:

## **Models of substance misuse**

There are four helpful theoretical models which may form the basis of interventions when working with substance misuse. Theoretical models help when you are planning interventions.

- **Biological models:** These models suggest that substance misuse is either a disease or a genetic predisposition. Interventions based on this model would include the approach of Alcoholics Anonymous which sees alcoholism as a disease and the only way of dealing with it is complete abstinence.
- **Psychoanalytic models:** These models suggest that substance misuse happens because of some unresolved psychodynamic conflicts. Interventions based on this model would include counselling or therapeutic group rehabilitation
- **Behavioural models:** These models suggest that substance misuse has been learned behaviour. Interventions would focus on teaching new behaviours through social skills training or CBT. The use of medication such as Antabuse which causes vomiting if the person taking it drinks alcohol is also behavioural in nature.
- **Multi-factorial models:** These models suggest that drug taking is the result of a range of factors. These may be biological, social and behavioural, as well as taking into account the actual drug taken and how it is taken. Interventions would focus on the meaning of the drug and drug setting for the young person and trying to work with them to address each of the factors in the drug taking scenarios.

Think about your own work setting. Are interventions with young people using drugs based on any particular model? How important would it be for collaborative practice to have a model underpinning work?



## **Understanding the rationale for approaches**

It is likely that you come into contact with substance misusers as part of your function. In whatever field you work, you may have come across terms like harm reduction or abstinence. Also you may have heard people discuss the pros and cons of individual versus group treatment approaches.

### *Harm reduction versus abstinence*

Harm reduction means that intervention is aimed at reducing the harm that a young person may be doing to themselves through their drug use. This is the principle behind interventions such as state provision of methadone, which happens in Scotland. In such programmes, the argument would be that if the user is taking methadone, they are not likely to harm themselves using street drugs of questionable quality. They are also less likely to commit crime to feed their habit, so the argument would be that methadone programmes also help to protect communities.

Abstinence is the principle which states that the only way for the problematic substance user to recover is to stop taking the substance completely. Research carried out by McKeganey, Morris, Neale and Robertson (2004) asserted that 60% of problematic substance users want to be drug free. This is a powerful statement. As a practitioner, it is important to remember that each of these approaches may have a role of play, but that it is important to actually listen to what the drug user wants as an outcome. As far as the group versus individual intervention is concerned, once again both types of intervention have their place. Group models give the person the additional support of group members as well as that of professional practitioners. It may be, however, that a group model does not fit well with the needs of the person at that time in their life. Once again, the important principle to remember is that the needs of the young person should be central to the intervention

### **Legal issues**

How does your legal system deal with young people with multiple needs that include misuse of substances? Where drugs and alcohol are concerned, the legal framework of the jurisdiction determines approaches to intervention with young people. Here are some observations from across jurisdictions:-

1. Criminalisation of possession and supply of drugs shapes the approaches to intervention with young people; entry into the

criminal justice system (which can be both positive and negative) sets up a particular pathway for dealing with substance misuse.

2. Different jurisdictions have different approaches to defining what is legal and what is not. The three areas of regulation are of alcohol, medicines (many of which have a potential to be misused) and illegal substances. There are grey areas. For example many opiates and benzodiazepines are manufactured and used clinically as well as illicitly.
3. The approach to enforcement varies across jurisdictions. All jurisdictions criminalise supply but there are different approaches and levels of tolerance to possession.
4. Social attitudes to misuse of all substances vary. For example, in some countries young people routinely experiment with substances from an early age and intoxication is seen as a right of passage. In other countries, the opposite applies.
5. Research (particularly in relation to Drug Courts and Juvenile Drug Courts in the United States) shows that coercion into treatment has equivalent outcomes to treatment being voluntary. Also, with young people, cognitive behavioural approaches produce better outcomes than other therapies.

You should now use the worksheet overleaf to find out or to explain the legislation relating to drugs in your country. When you have finished put this onto the online platform

<i>COUNTRY</i>	<b>[Insert name of your country]</b>	
<b>Substance misuse is</b> ( <i>give and overview of the extent and nature of the problem as you find it in your work</i> )		
<b>Issue</b>	<b>How approached in your jurisdiction</b>	<b>What is the relevant law?</b>
Supply of alcohol to young people		
Age at which it is legal to possess alcohol or drink		
How are medicines regulated		
How are illegal substance regulated		
What distinction is made between possession and supply of illegal substances		
What powers do the police have to deal with young people using drugs or alcohol		
What rights do the police have to search people and enter premises		
What is the typical path through your		

criminal justice system for a young person with increasingly chaotic substance misuse		
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#### **Activity Four: Some strategies to improve mental health**

**Objectives:** Participants will

- Learn about some approaches to improving mental health
- Reflect on any particular approach they use in their own workplace which improves mental health and be prepared to do a short presentation on this at the next face-to-face day.

#### **Task 1**

Watch the following two short video clips on positive psychology

1. What is Positive psychology?

<http://www.youtube.com/watch?v=1qJvS8v0TTI>

2. Martin Seligman discusses well being on BBC Newsnight

<http://www.youtube.com/watch?v=Q-Vhjmdp4nI>

Take some personal notes for later reflection. In particular, note any of the concepts mentioned in the clips (e.g. learned helplessness, mindfulness etc)

Now read the following paper using the critical appraisal tool in Appendix Two.

What is Positive Psychology and what is it not?

<http://www.psychologytoday.com/blog/the-good-life/200805/what-is-positive-psychology-and-what-is-it-not>

### Task 3

Resilience is a key concept when working to improve the mental health of young people. This activity will involve looking at the concept of resilience and how it interlinks with other concepts.

Look at the following video entitled *Resilience in teenagers*. It can be found at the following link:

<http://www.youtube.com/watch?v=azftoaZLLeo>

While watching the video, note the following information

What is the definition of resilience	
The five key components of resilience	
1	
2	
3	
4	
5	
Ten ways to build resilience	
1	
2	
3	
4	
5	
6	
7	
8	

9	
10	

Now read the following paper on resilience and attachment, using the critical appraisal tool. The paper is entitled *Attachment and resilience: Implications for children in care* at the following link:

[http://conversation.lausanne.org/uploads/resources/files/795/RES038\\_Attachment\\_and\\_Resilience\\_Implications\\_for\\_Children\\_in\\_Care.pdf](http://conversation.lausanne.org/uploads/resources/files/795/RES038_Attachment_and_Resilience_Implications_for_Children_in_Care.pdf)

Now within your own work, think of one example of how you can put into action each of the ten ways to build resilience.

Ten ways I may build resilience in my practice with young people	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

#### **Task 4**

You have looked at two of the ways that strategies from research and practice can be used to improve the mental health of young people. Now think about a strategy you use in your workplace. Write a brief description below and be prepared to give a short presentation of this during the next face-to-face day.

#### **A strategy for promoting positive mental health in my workplace**

#### **Activity 5: International work**

**Objectives :** Participants will

- Look at the video clips for the other five countries in the project

- Choose one of the case studies from each country on the online platform and examine them for similarities and differences to their own experience

For this activity you should look at the video clips for each of the countries taking part in the project. After watching the video clips, write your impressions of how the services differ from your own services. Keep this for your portfolio.

**MY IMPRESSIONS FROM THE VIDEO CLIPS:**



Now choose one of the case studies from each country. Read each case you have chosen. Identify the similarities and differences between the cases, using the template below:

<b>CASE STUDIES</b>	
<b>TOPIC</b>	<b>MY COMPARISONS</b>
Age, gender, ethnic origin	
History and reasons for contact with social and health services	
What are the behaviours that make the young	

<p>person so challenging for you?</p>	
<p>Number of residential/foster placements in throughout their life</p>	
<p>Do they have a diagnosis of a mental health disorder ? If yes, how helpful has this been?</p> <p>If no, do you think the young person should have a diagnosis?</p>	
<p>What strategies / treatment do you currently use to tackle the behaviours that are challenging you?</p>	
<p>How has the young person been viewed buy society? Which 'image of childhood' has been most applied to their situation?</p>	
<p>What is their family structure? What are the parents/main carers like?</p>	

What strategies do you currently use to engage with the parents or carers of the young person?	
What types of trauma and neglect has the young person been exposed to, and at what ages?	
In your joint opinion, how has the young person's 6 core strengths been affected by the trauma and neglect?  7. Attachment  8. Self regulation  9. Affiliation  10. Awareness/Attunement  11. Tolerance  12. Respect	
How does this link to the behaviours that make the young person so challenging for you?	

Developmental issues	
Social factors	
Loss and separation	
Change and transition	
Trauma	

Violence	
Scapegoating	
Secrecy	
Culture	

Now write a critical reflection on how understanding the similarities and differences can help or hinder inter-professional practice. Highlight what, for you, are the main challenges to inter-professional practice,

the main promoters of inter-professional practice, and the main thing you have learned so far from the international comparisons you have made. This reflection should be no more than 2000 words and should be included in your portfolio.

## **APPENDIX ONE: Effects of parental substance misuse**

Read this extract from a review paper which outlines the impact of substance misuse, using the critical appraisal tool in appendix two.

(The full reference is Velleman, R and Templeton, L. (2007) Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment*, 13: 79-89. The full paper is available at <http://apt.rcpsych.org/content/13/2/79.full> )

### **The impact of parental substance misuse on children**

The negative impact of problems arising from parental substance misuse (particularly alcohol and illegal drugs) on children (Cleaver et al, 1999; Harbin & Murphy, 2000; Tunnard 2002a,b; Kroll & Taylor, 2003; Barnard & McKeganey, 2004; Gorin, 2004) and young adults (Velleman & Orford, 1999) has been well documented (Velleman, 2004), and has been acknowledged in two key government publications (Advisory Council on the Misuse of Drugs, 2003; Prime Minister's Strategy Unit, 2003).

Section one of this paper outlines the common structures and functions within the family that are often disrupted by alcohol or drug misuse. Section two describes some of the common negative experiences that children and adolescents may have when living with a parent with a substance misuse problem. These and other disruptions can have a strong impact on children at all stages of their development, placing them at risk of developing a wide range of problems which are outlined in Section three. Many children affected by problem substance use within the family environment will reach the attention of social and mental health services because of concerns regarding child protection (Forrester & Harwin, 2004). The issues outlined in Sections 2 and 3 relate to both alcohol and drug misuse, but additional problems can arise when the parent misuses illicit drugs. These include the illegal nature of drug misuse, the modes of ingestion, the links to crime, the use of the family home for groups of people to take drugs (drug misuse is more likely to be a home-based activity), and the even stronger links with poverty, unemployment and social deprivation.

#### ***Section One : Structures and functions within the family often disrupted by alcohol or drug misuse***

- Rituals: the ways families celebrate religious or family occasions such as Christmas or birthdays

- Roles: as one family member develops a substance problem, others take over their roles, such as finances, disciplining, shopping and cleaning
- Routines: when behaviour becomes unpredictable it creates difficulties for the family in planning or committing to routines: will she remember to collect her son from school? When will he come home, and in what state?
- Communication: alcohol and drugs have a major effect on communication between family members
- Social life: families tend to become increasingly socially isolated, owing to the difficulty of explaining to friends and neighbours that a family member has a drug or alcohol problem, or the social embarrassment or unpredictability associated with drinking and drugs
- Finances: a family's finances can be hugely affected by reduction in income (e.g. owing to job loss) and spending of such income as is obtained on alcohol or drugs instead of more vital items
- Relationships and interactions: for example both the misuser and their partner may become much more neglectful of other family members; aggression and violence are much more likely: more than 80% of cases of violence between spouses are alcohol-related and 20–30% of child abuse cases involve parents who are heavy drinkers (similar findings arise with the families of problem drug users)

***Section two: Negative experiences of children and adolescents living with parental substance misuse***

- High levels of violence
- Experiencing or witnessing neglect or abuse – physical, verbal or sexual
- Poor and/or neglectful parenting
- Inconsistency from one or both parents
- Having to adopt responsible or parenting roles at an early age
- Feeling negative emotions such as shame, guilt, fear and embarrassment
- Possible neurodevelopmental consequences of substance misuse in pregnancy (e.g. foetal alcohol syndrome) that may contribute to developmental delays or intellectual disability

### ***Section three: Negative effects of living with a parent with a substance misuse problem***

#### *Children*

Children who have the experiences outlined in section two often subsequently demonstrate their negative effects, including higher levels of:

- behavioural disturbance, antisocial behaviour (conduct disorders)
- emotional difficulties
- behavioural problems and underachievement at school
- social isolation, because they feel that it is too problematic or shameful to bring friends home, or because they are not able to go out with friends as they have responsibilities of caring for other family members (e.g. siblings or the misusing parents)
- 'precocious maturity'

They also tend to have a more difficult transition from childhood to adolescence and increased likelihood of being referred to social services because of child protection concerns

#### *Adolescents*

Two common patterns often emerge:

- increasing introspection and social isolation, with friendship difficulties (e.g. the young person is unlikely to visit or invite friends to their own home), anxiety or depression (for which psychoactive medication may be prescribed); attempts to escape their family home (e.g. by leaving home at an early age or entering into a long-term relationship)
- development of strong peer relationships which are kept separate from their own family; these relationships may themselves involve early alcohol or drug use, participation in sub-cultures perceived to be 'deviant', in antisocial activity, unsafe sex and unplanned and/or early pregnancy

Factors in parents' lives and relationships have the potential to exacerbate the problems summarised in the previous 3 sections (Cleaver et al, 1999; Velleman & Orford, 1999; McKeganey et al, 2002). These factors, which are summarised in Section 4, have a cumulative



effect: the more that are present, the higher the risk of negative outcomes.

***Section four: Risk factors leading to generally worse outcomes***

*General factors*

- High levels of family disharmony
- Domestic violence
- Physical, sexual or emotional abuse
- Inconsistent, ambivalent or neglectful parenting
- The absence of a stable adult figure (such as a non-using parent, another family member or a teacher)
- Parental loss following separation or divorce
- Material deprivation and neglect
- The family not seeking help

*Substance-specific factors*

- Both parents being substance misusers
- Substance misuse taking place in the home
- Greater severity of the problem

*Drug-related factors*

- Exposure to and awareness of criminal activity (e.g. drug dealing)
- Presence of the child (although not necessarily in the same room) when drugs are taken
- Witnessing someone inject drugs and seeing paraphernalia (e.g. lying around the house)

## **APPENDIX TWO**

### **Critical appraisal tool**

This critical appraisal tool is adapted from one developed by Long AF, Godfrey M, Randall T, Brettle AJ and Grant MJ (2002) *Developing Evidence Based Social Care Policy and Practice*. Leeds: Nuffield Institute for Health.

#### *(1) INTRODUCTION*

If the paper has an introduction or an abstract, what are the aims of this paper ?

#### *(2) CONTEXT*

What type of paper is this? Is it a research paper, a summary, a report, a review or something else?

What geographical and health/care setting is the paper addressing? Over what time period is the paper addressed? How recently was the paper published?

#### *(3) ANALYSIS*

Give a brief outline of the summary or recommendations of the paper. What are its key aims? What data collection methods or sources of information were used in the paper? How wide or selective were the sources? How well is the analysis laid out? Are arguments clear? Is there clear evidence for any statements made? Are recommendations or conclusions valid and reliable given the information collection?

If it is a research paper, is the research methods adequately described? How were the data analysed? How adequate is the description of the data analysis? Are the findings interpreted within the context of other studies and theory? What was the researcher's role? Are the researcher's own position, assumptions and possible biases outlined?

What are your own views about the paper? What have you learned and what could be clearer? Have you any unanswered questions as a result of reading the paper? What could have been done better?

#### *(4) POLICY AND PRACTICE IMPLICATIONS*

Implications: To what setting are the paper's findings generalisable? To what population are the paper's findings generalisable? Is the conclusion justified given the analysis and the information gathered?

What are the implications for policy? What are the implications for service practice?

### **APPENDIX THREE**

Write a short reflective log about your work in looking at the issues of self harm OR substance misuse. Think about any part of the learning within this module which caused you to stop and think, and about how the learning may impact on your practice in the future.

**Description**

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

**Action Plan**

## References

Advisory Council on the Misuse of Drugs (2003) Hidden Harm: Responding to the Needs of Children of Problem Drug Users. The report of an Inquiry by the Advisory Council on the Misuse of Drugs. London: TSO

Barnard, M. & McKeganey, N. (2004) The impact of parental problem drug use on children: what is the problem and what can be done to help? *Addiction*, 99, 552–559.

Barrett, A. and Turner, R. (2006) Family structure and substance use problems in adolescence and early adulthood. Paper presented at the annual meeting of the American Sociological Association.

Briere, J. & Runtz, M. (1993) Childhood sexual abuse: long term sequelae and implications for psychological assessment. *Journal of Interpersonal Violence*, 8, 312–330.

Canning, U., Millward, L., Raj, T. & Warm, D. (2004) Drug use prevention among young people: A review of reviews. London: HMSO.

Cleaver, H., Unell, I. & Aldgate, J. (1999) *Children's Needs – Parenting Capacity*. London: TSO

Forrester, D. & Harwin, J. (2004) Social work and parental substance misuse. In *Children Exposed to Parental Substance Misuse: Implications for Family Placement* (ed. R. Phillips), pp. 115–131. London: British Agencies for Adoption and Fostering

Gorin, S. (2004) *Understanding What Children Say. Children's Experiences of Domestic Violence, Parental Substance Misuse and Parental Health Problems*. London: National Children's Bureau.

Harbin, F. & Murphy, M. (2000) (eds) *Substance Misuse and Child Care: How to Understand, Assist and Intervene when Drugs Affect Parenting*. London: Russell House Publishing.

Kroll, B. & Taylor, A. (2003) *Parental Substance Misuse and Child Welfare*. London: Jessica Kingsley

Johnson, S. (1997) Dual diagnosis of severe mental illness and substance misuse: a case for specialist services? *British Journal of Psychiatry*, 171, 205–208.

McKeganey, N., Barnard, M. & McIntosh, J. (2002) Paying the price for their parents' addiction: meeting the needs of the children of drug-using parents. *Drugs: Education, Prevention and Policy*, 9, 233–246.

McKeganey, N.P., Morris, Z., Neale, J., Robertson, M. (2004) What are drug users looking for when they contact drug services: Abstinence or harm reduction. *Drugs: education prevention and policy*. 11(5), 423–435.

Parker, H., Aldridge, J. & Measham, F. (1998) *Illegal leisure: The normalisation of adolescent drug use*. London: Routledge.

Prime Minister's Strategy Unit (2003) *National Alcohol Harm Reduction Strategy: Interim Analysis*. Strategy Unit.

[http://www.number10.gov.uk/files/pdf/SU%20interim\\_report2.pdf](http://www.number10.gov.uk/files/pdf/SU%20interim_report2.pdf)

Raine, P. (2001) *Women's perspectives on drugs and alcohol: The vicious circle*. Aldershot: Ashgate.

Shaw, A., Egan, J., & Gillespie, M. (2007) *Drugs and poverty: A literature review*. Glasgow: Scottish Drugs Forum.

Tunnard, J. (2002a) *Parental Problem Drinking and its Impact on Children*. *Research in Practice*.

<http://www.rip.org.uk/publications/documents/researchreviews/ALCOHOL.pdf>

Tunnard, J. (2002b) *Parental Drug Misuse: A Review of Impact and Intervention Studies*. *Research In Practice*.

[http://www.rip.org.uk/publications/documents/researchreviews/drugs\\_misuse.pdf](http://www.rip.org.uk/publications/documents/researchreviews/drugs_misuse.pdf)

Velleman, R. (2004) Alcohol and drug problems in parents: an overview of the impact on children and implications for practice. In *Seriously Disturbed and Mentally Ill Parents and their Children* (2nd edn) (eds M. Gopfert, J. Webster & M. Seeman), pp. 185–202. Cambridge: Cambridge University Press.

Velleman, R. & Orford, J. (1999) The adulthood adjustment of offspring of parents with drinking problems. *British Journal of Psychiatry*, 162, 503–516

Wincup, E., Buckland, G. & Bayliss, R. (2003) *Youth homelessness and substance use: Report to the drugs and alcohol research unit*. London: Home Office Research, Development and Statistics Directorate.

**Evaluation form**

**Module Two: Part four - Self study and e-learning**

**Can you please provide some comments on the following:**

<p><b>The handbook for self study and e-learning</b></p>	
<p><b>The methods used (reading, critical appraisal, online platform, websites and links)</b></p>	
<p><b>Did you need any tutor support during this part of the course? If yes, what did you need and why?</b></p>	
<p><b>Content of the handbook</b></p>	

<b>Guidance for activities</b>	
<b>Guidance on what you had to do for your portfolio</b>	


***Module three***

***Inter-professional issues and collaboration***

***Part one: Borderline collaboration***

***Face-to-face day***



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### ***About this module***

**This is the third and final module of the course. The module is called *Inter-professional issues and collaboration*. It is recognised that throughout the course, you have been learning and reflecting on inter-professional practice. The focus of the course has gradually shifted from you as an individual practitioner, to inter-professional discussions have around workplace practice. This was done on purpose as one impetus for change comes from the grass roots of direct practice with young people. However, it is recognised that organisations also have an effect on collaboration. This module gives you the opportunity to reflect on the nature of organisations, identify areas and strategies for collaboration, and reflect on how to develop and promote the best collaborative practice.**

**The first day of this module is a face-to-face day. On your face-to-face day, you will be working in your groups with your tutor. This handbook outlines the activities you will undertake on the face-to-face day. It has clear guidance on what objectives should be met at the end of each activity.**

**At the end of your face-to-face day, you will be given the handbooks on how to complete the next two parts of the module. For the next two parts, you will be expected to carry out reading and activities and also to access the online platform. You are also expected to undertake a work shadowing placement. Guidance on what is expected will be given by your tutor at the end of this face-to-face day.**

***Module Three: Inter-professional issues and collaboration***

**This module provides the opportunity for the professionals involved in borderline practice to examine some of the organisational issues affecting collaboration and to develop strategies to improve collaborative practice.**

**The aim of the module is to understand, undertake and promote the best collaborative practice.**

**The objectives of the module are**

- **To explore some of the theories of organisations and organisational change**
- **To critically appraise their own organisation and its capacity for change**
- **To experience work in another setting on the borderline**
- **To identify an area for change in inter-professional practice which they can implement in their own workplace and compile a research and development report on this area**
- **To prepare for the national seminar day**

**Day One: Face-to-face day**

**9.00 – 10.30: Arrival, registration and re-orientation**

- 10.30 – 10.45: Break**
- 10.45 – 12.15: Developing strategies for collaboration**
- 12.15 – 1.15: Lunch**
- 1.15 – 1.30: After lunch plenary and activity**
- 1.45 – 2.30: Developing and using a shared language**
- 2.30 – 2.45: Break**
- 2.45 – 3.30: Developing a shared language (cont)**
- 3.30 – 4.30: Preparation for e-learning and evaluation**

**Activity 1 : Arrival, registration and re-orientation**

**Time to complete the activity: 90 mins**

**Objectives : Participants will**

- **Feel comfortable in the training**
- **Provide a reflective space for discussion of the activities undertaken in the last module**

- **Get an opportunity to have re-orientate yourself to the group**

**Your tutor will lead you through an introductory activity, re-state the ground rules and go over the programme for the day.**

**During the last self-study period, participants had two pieces of work to complete. One was an international comparison of cases and the other was the identification of strategies to improve the mental health of young people.**

**In the large group, each person should now give a short feedback on what they learned from each category of the international comparisons of cases. The tutor will write up the comparisons on a flipchart or white board, collate these and put them on the online platform. The template for this groupwork is given overleaf.**

<b>CASES</b>	
<b>TOPIC</b>	<b>GROUP CONSENSUS FORM</b>
	<b>[INSERT THE NAME OF YOUR OWN COUNTRY]</b>
<b>Age, gender, ethnic origin</b>	
<b>History and reasons for contact with social and health services</b>	

<b>What are the behaviours that make the young person so challenging for you?</b>	
<b>Number of residential/foster placements in throughout their life</b>	
<b>Do they have a diagnosis of a mental health disorder ? If yes, how helpful has this been?</b>  <b>If no, do you think the young person should have a diagnosis?</b>	
<b>What strategies / treatment do you currently use to tackle the behaviours that are challenging you?</b>	
<b>How has the young person been viewed buy society? Which 'image of childhood'</b>	

<p><b>has been most applied to their situation?</b></p>	
<p><b>What is their family structure? What are the parents/main carers like?</b></p>	
<p><b>What strategies do you currently use to engage with the parents or carers of the young person?</b></p>	
<p><b>What types of trauma and neglect has the young person been exposed to, and at what ages?</b></p>	
<p><b>How have young people's 6 core strengths been affected by the trauma and neglect?</b></p> <ul style="list-style-type: none"> <li><b>13. Attachment</b></li> <li><b>14. Self regulation</b></li> <li><b>15. Affiliation</b></li> <li><b>16. Awareness/Attunement</b></li> <li><b>17. Tolerance</b></li> <li><b>18. Respect</b></li> </ul>	
<p><b>How does this link to the behaviours that</b></p>	

<b>make the young person so challenging for you?</b>	
<b>Developmental issues</b>	
<b>Social factors</b>	
<b>Loss and separation</b>	
<b>Change and transition</b>	



<b>Trauma</b>	
<b>Violence</b>	
<b>Scapegoating</b>	
<b>Secrecy</b>	
<b>Culture</b>	
<b>Something we have learned about borderline work from each country</b>	

**Country 1 [insert name of country]**

**Country 2 [insert name of country]**

**Country 3 [insert name of country]**

**Country 4 [insert name of country]**

**Country 5 [insert name of country]**

**Now the group members should look at the strategies to improve mental health that they have used in their own workplaces. During the last period of self-study/e-learning, participants were asked to come to this session prepared to give a short presentation on some strategy they use in work which helps to improve the mental health of young people. They should now each give a short presentation of the strategies to the large group. Your tutor will facilitate the presentations and feedback. The discussion should centre on the question:**

***Can this strategy be used by me in our organisations? If yes, what makes it transferable? If no, what are the barriers to implementation across this borderline?***



## **Activity 2 : Developing strategies for inter-professional collaboration**

**Time to complete the activity: 90 mins**

**Objectives : Participants will**

- **Reflect on the nature of their organisation**
- **Identify how to overcome some of the organisational barriers to inter-professional practice**

**In the previous activity, you were asked to think about how strategies used in other organisations can be transferred to your organisation. Now you will be asked to think about one small organisational change that you can make within your organisation to help improve inter-professional practice.**

**For this task you will be working in your inter-professional pair with the person whom you will be undertaking your work shadowing placement. Take some time to discuss an idea which you could implement in each of your organisations which you think could help inter-professional collaboration. Make a brief note of your two ideas below:**

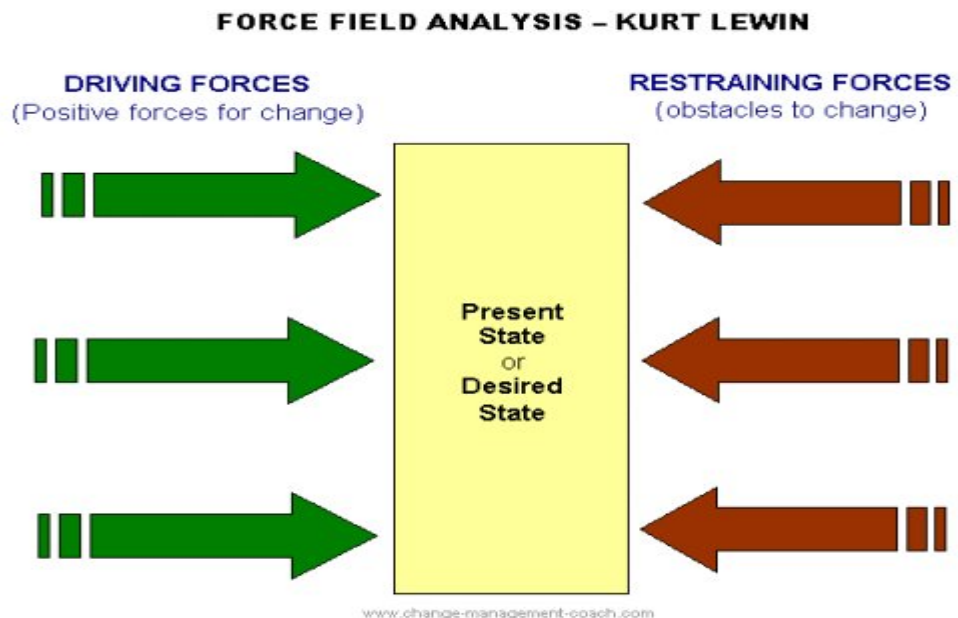
***Idea of a change in relation to inter-professional practice in my organisation and how it may benefit young people on the borderline :***

***Idea of a change to inter-professional practice in my partner's organisation and how it may benefit young people on the borderline:***

Now, still in your pairs, read this short article on implementing changes. This article outlines the work of Lewin on how to analyse the aspects of change so that you can implement something in a more effective way.

### Force field analysis as a model for change

Kurt Lewin wrote that 'An issue is held in balance by the interaction of two opposing sets of forces - those seeking to promote change (driving forces) and those attempting to maintain the status quo (restraining forces)'. This is summarised in the diagram below.



Before any change process, the force field is in equilibrium between forces favourable to change and those resisting it.

For change to happen, the equilibrium must be upset – either by adding conditions favourable to the change or by reducing resisting forces.

What Kurt Lewin proposes is that whenever driving forces are stronger than restraining forces, the status quo or equilibrium will change. If we apply this to understanding any change process, it is obvious that we must analyse it into the driving forces and the restraining forces.

There will always be driving forces that make change attractive to people, and restraining forces that work to keep things as they are. Successful change is achieved by either strengthening or adding to the driving forces, or by weakening or reducing the number of restraining forces. Over the page is an example of how a force field analysis may be applied to an idea for change.

“My idea is to start an inter-professional writers group. This would involve staff from mental health services and residential services getting together in some way to collaborate on looking at various aspects of practice and writing a short joint practice paper improvement statement.”

<b>Driving forces</b>	<b>Restraining forces</b>
<b>The enthusiasm from attending the course and wanting to build on these relationships</b>	<b>Finding a common time to meet</b>
<b>Our requirements for continuing professional</b>	<b>Not having time to attend or time to write a paper</b>

<b>development from our professional bodies</b>	
<b>Our passion for children and a belief that inter-professional working will help improve outcomes</b>	<b>The thought of taking responsibility to run the group</b>
<b>Personal motivation to keep learning</b>	<b>Getting a place for us to meet</b>
<b>Improving my CV as I will be developing a new skill</b>	<b>Other priorities taking over</b>

***How can I strengthen the driving forces and reduce the restraining forces?***

<b>Explain to my manager that the writing group will go toward my CPD and re-registration</b>	<b>Set up an internet meetings site where we can put in our time slots for possible meetings</b>
<b>Let managers know that the written statements will have our name on them, thereby promoting the organisation</b>	<b>Try to get the meetings to happen at my unit as I can't often leave ! How about the interview room? During the day tends to be good !</b>
<b>Potential for publication in our professional magazines. Again good promotion for the organisation</b>	<b>Timetable meeting into the workplace diaries so that it gets taken into account with other part of the workload</b>
<b>Any new skills or methods put forward by our inter-professional colleagues can add to our own organisation's range of practice tools and interventions</b>	<b>Each member of the group to take it in turn to lead the writing. Each member of the group to put the time slot in their diary and protect it.</b>

**On the previous page was a very simple example of force field analysis. Now look at your two ideas and think about how you**

might implement them using this force field analysis. Think of the restraining forces and the driving forces. Think about how you can reduce the restraining forces and build the driving forces. Write in your analysis below:

*Idea for my organisation:*

Driving forces	Restraining forces



--	--

***Idea for my partner's organisation:***

<b>Driving forces</b>	<b>Restraining forces</b>


**Once you have completed this, get together once again in the larger group and discuss the ideas and how you think they can be implemented. Your tutor will note up the key drivers and barriers to organisational change and inter-professional collaboration that seem to be emerging from the analyses and discussion. This will be noted on the template overleaf by your tutor and be put onto the online platform.**

**[Insert name of your own country]**

<b>Main Driving Forces for inter-professional collaboration</b>	<b>Main Restraining forces for inter-professional collaboration</b>

**Activity 3 : Warm up after lunch**

**Time to complete the activity: 15 minutes**

**Objectives : Participants will**

- **Feel comfortable in the training**
- **Get an opportunity to have some fun and waken up**
- **Reflect briefly on the morning and be introduced to the afternoon session**

**Your tutor will lead you through a warm up activity**

**Activity 4: Preparation for placement**

**Time to complete the activity: 15 minutes**

**Objectives : Participants will**

- **Have the opportunity to go over the expectations of the placement**
- **Ensure that they have all of the guidance they need for the reflective writing and work shadowing report to be written**

**The tutor will now give out the placement handbook. The first section of the placement handbook should be worked through with the group to make sure that everyone is ready for their work shadowing placement**

## **Activity 5 : Developing and using a shared language**

**Time to complete the activity:45 mins**

**Objectives : Participants will**

- **Role play how to communicate the needs and symptoms of a young person to a mental health professional.**

**Residential staff and social pedagogues should read the following case study. You want to make a referral to mental health services. Your task is to describe the key issues to your mental health practitioner partner. Your partner will give you feedback on how you have presented the issues .**

***Sammy is 15. He has been in a residential child care since he arrived in your country two years ago. He is Somalian and is an unaccompanied asylum seeker. His village was destroyed during the civil war in Somalia and the majority of his family killed. He became a child soldier for a time before he was found by his brother. He went with his brother to a refugee camp and the remaining family pooled their wealth to pay for Sammy to come to your country. He was picked up by social services shortly after arrival. The gang that had brought him in to this country were offering him as a male prostitute. For his own safety and as part of the policy of dispersal of refugees, he was placed in residential child care.***

***When he came to your country, Sammy would not speak, exhibited obsessional behaviour over simple routines (such as eating or washing) and hid for long periods in a cupboard in his room. Till recently, Sammy has been doing a bit better and seems a resilient young man. He has learnt the language of his adopted country and is expected to do well at school. He is proud of his African roots and wants eventually to return home. He still has flashbacks and when under stress, behaves compulsively. He has recently been having very bad nightmares and has started to become extremely aggressive if his personal space is invaded in any way. You are concerned at the change in his behaviour.***

***Staff have been helping Sammy maintain his cultural roots. With the assistance of a local organisation, Refugee Aid, a family of***

***asylum seekers from a neighbouring village was identified and has befriended Sammy. He visits the family most Sundays, which has become a very special day. An important aspect of the contact is that the family is the only one in the city that uses Sammy's local dialect – which is important to him as a cultural link.***

***After his most recent visit Sammy was talking with a member of staff, who had asked him what he did on the visits. He said that 15 is a significant age in his culture, the threshold of manhood. On the last two visits he has been invited to join the men after the communal meal. They sit in a room, story telling, and smoking a communal hookah which contains cannabis. This is the norm in Sammy's culture and an important rite of passage for boys to be accepted into manhood. He said that it stops his flashbacks, helping him to feel relaxed and untroubled.***

#### **Activity 5 : Developing and using a shared language (cont)**

**Time to complete the activity:45 mins**

**Objectives : Participants will**

- **Look at their case study and explain to the mental health professional what they think the key issues are for the young person and argue for a referral to mental health service**

**This activity builds upon the last activity. Using the feedback you received from the *Sammy* case study, re-examine your case study and present to your partner some of the issues from a mental health perspective and argue as to why a referral to mental health services may help the young person.**

#### **Activity 6: Next steps and evaluation**

**Can you please complete the evaluation form at the end of this module?**

**Evaluation form**

**Module three: face to face day one**

**Can you please provide some comments on the following:**



<b>The module handbook</b>	
<b>The methods used (self study, learning sets, pairs work etc)</b>	
<b>Tutor support</b>	
<b>Venue</b>	
<b>Content of the module</b>	

<b>Standard of work expected</b>	
<b>What you had to do for your portfolio</b>	

***Module three***

***Inter-professional issues and collaboration***

***Part two: Organisational development***

***Self-study and e-learning***



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### ***Introduction***

**Welcome to this handbook. It contains information and instructions on how to complete part two of module three. For this part of your learning you will be working independently, carrying out a range of activities relating to organisational development.**

**Inter-professional practice by its very nature implies involvement of two or more people. Practitioners participate in many group activities, especially formal and informal meetings. We will now look at the behaviour of people in groups or organisations. It is important to think about this area in order to analyse more clearly what is happening when staff from different organisations try to work together. We will take a brief look at organisations and how they can have an impact upon inter-professional practice. During the discussion, barriers to collaborative practice will be highlighted, and ways to deal with these will be explored.**

#### ***Why examine organisations and groups?***

**There will be many occasions in the working day when the mental health worker or the residential worker has to make contact with staff from different professional groups or organisations. In addition, mental health workers or residential workers may have to work alongside different professionals in a group situation, for example during child care reviews or at case conferences. On many occasions, these collaborations will be fruitful and successful, achieving the desired outcomes for all parties. On other occasions, however, the discussions or meetings may be fraught and unsatisfactory, leaving all participants with a feeling of frustration. Why is it that seemingly reasonable, pleasant and intelligent individuals can leave each other with such negative feelings on occasions such as these? One answer is that when mental health workers or residential workers deal with a professional from another agency, they not only deal with the individual as a person, but they also with deal with them as a member of their work group and profession, and a representative of their organisation. We have already reflected on the impact of different professional codes and structures on inter-professional relationships. Now we will spend some time looking at the impact of the organisation and what we can do about this.**

**Activity 1 : Understanding organisational models and culture**

**Objectives : Participants will**

- **Reflect on the characteristics of organisations**
- **Begin to explore how these can create barriers to work at the borderline**

**Imagine you have a meeting with another professional who is either residential worker, social pedagogue or a mental health worker (not from your own professional group) about a young person with whom you are both involved. The meeting is being held with a view to finding some way to help the young person to move onto independent living. When you meet with this other professional, try to think of them as the person at the head of a queue. The queue consists of the same person, but with various 'hats' on: the professional as a person, as a representative of their workplace, as a member of their wider agency, as a part of the local authority and so on. This picture is further complicated by you as the other professional. You, also, are at the head of your own queue. When you begin to conceive of inter-professional practice in this way, it becomes easier to see the complexity of the task and the need to understand the various factors which can influence how another person sees their role.**

***What do practitioners need to know about the nature of organisations?***

**There has been much research into the nature of organisations. Although it is outwith the scope of this module to present a full exploration of organisational theory, it is helpful to have an overview of some of the relevant research and to consider what implications this might have for inter-professional practice. We will give a brief introduction to some of the basic models that have been developed in order to analyse the structure of organisations, and then we shall go on to examine the concept of organisational culture.**

***Organisational models***

**The study of organisations has its roots in early sociology. Weber conducted one of the first analyses of modern organisations and developed the model of the bureaucracy. The work of sociologists such as Weber was in response to a changing, industrialised Western world, which was creating large-scale industrial enterprises and large government departments, which required**

**new, more efficient, methods of management, recruitment and promotion on the basis of merit, and so on.**

The early theories took a *rational-legal* view which essentially conceived of organisations as machines. Early theorists such as Frederick Taylor applied the *rational-legal* perspective in his study of organisations and workforces, in an approach called *Scientific Management*. Subsequent researchers began to visualise organisations in a less mechanistic way, and this perception of the organisation as a 'living entity' became known as the *Human Relations* school. As technology advanced, and new concepts became available, theorists began to think of the organisation in terms of *systems* with their defining features of being in flux and having feedback and control mechanisms or subsystems. More recently, commentators such as Lewin have discussed how ideas based on chaos and complexity theory can help people to understand how organisations operate. Concepts based on chaos and complexity ask practitioners to view the organisation as a complex pattern which, while having many general properties, can develop in startlingly different ways depending on tiny variables within its functioning.

These varying conceptualisations can each be useful in helping people to see how structures in organisations can have an impact on inter-professional practice. However, the key point for mental health practitioners and residential practitioners to remember is that influential organisational theories such as those drawn from 'Human Relations' share an understanding that the structure of any organisation has two essential aspects; the formal and the informal. The formal aspect can be described by looking at organisational charts, job roles and structure. The other is the informal part consisting of the social relationships which develop within the organisation, based on spontaneous human behaviour. Bearing this in mind can also be helpful when analysing inter-professional practice. The implication of this distinction is that people may *think* they understand an organisation because they know its roles and functions. However, practitioners in any field also have to relate to individuals within the organisation and it is important to have their views of what they *perceive* their function to be within the wider organisation, and how this affects their work with other professionals.

### ***Activity 2***

Think of the organisation you are working in. What are the formal aspects of the organisation? What are the informal aspects of the

organisation? If you have been the member of a large organisation you may be able to reflect on the fact that teams or units within the same organisation can vary in many ways, despite having apparently similar remits, policies and procedures. Think about how two teams with similar roles and run by the same agency (e.g. 2 residential child care units run by the same local authority or two mental health teams run by the same agency) could feel so different. Discuss what you think contributes most to how a worker feels in their work environment; the formal or informal aspects.

### ***Organisational Culture***

Another important concept which helps understand the impact of organisations on the individuals who work in them is the notion of organisational culture. Scott, Mannion, Davies and Marshall (2003) in their discussion of organisational culture in healthcare explore the difficulties involved in trying to precisely define what organisational culture means. They claim that organisational culture:

broadly signifies a symbolic approach to organisations in order to study characteristic ideologies, language, dress codes, behaviour patterns, signs of status and authority, modes of deference and misbehaviour, rituals, myths and stories, prevailing beliefs, values and unspoken assumptions (2003: 65).

The organisational culture refers to the 'feel' of the organisation, and is closely connected to the informal aspects of organisation as described above. Much of the research into organisations in general and organisational culture in particular, has focussed on large private companies, but the findings are also relevant to the public sector.

The importance of organisational culture as a concept really took hold of the imagination of managers after the publication of Peters and Waterman's (1982) book *In Search of Excellence*. In this book the authors claimed that organisational culture was central to the success of the firms in the study. The significance of factors such as professional identity and occupational orientation may be one of the keys to help unlock the organisational culture within the public services. Scott et al. (2003) talk helpfully about this when they refer to aspects such as professional identity and occupational orientation as *sub-cultures*. They say that analysis of



**any specific work environment would benefit from an analysis of the specific sub-cultural mix.**

**Depending on the professional group, some sub-cultures will be more significant than others. This is a key point when analysing inter-professional practice, as an examination of these different sub-cultures can immediately indicate where potential areas of commonality and conflict lie between professional groups. For example, one of the sub-cultures identified by Scott et al. (2003) above was *occupational orientation*. Occupational orientation refers to how the individual sees themselves in relation to their work. A person may identify most closely with their profession rather than their agency. Alternatively, they may see themselves as an agency person whose first point of identification is with the corporate body (for example the local authority). Yet another person may simply identify themselves with their place of work. If a comparison is made between residential workers and mental health practitioners, differences within each of the subcultures can be detected. Some of our previous discussion around codes of practice may suggest, for example, that nurses tend to have a strong identification with the profession. Social pedagogues and residential workers are a much more heterogenous group. Some may have a strong identification with the profession but given their relatively new professional status in different parts of Europe, there may also be a stronger identification with the agency or the individual group care home.**

### ***Activity 3***

**Given the analysis above, try to identify some points of commonality and some points of divergence which may have an effect on inter-professional practice between residential workers, and nurses, using the sub-culture of professional identity. Look at the analysis carried out on the sub culture of occupational orientation and repeat this process using the sub-culture of professional identity as the analytical tool.**

### ***Comment on activity***

**Hopefully, this brief analysis will have revealed that groups of workers from different professions may have very different perceptions about their activity, based on the subcultures of professional identity. This in turn should alert practitioners to the ways in which these subcultures can help or hinder inter-professional practice. If practitioners can identify the meeting points in the subcultures, these can form a common platform for**

**discussions. For example, strong identification with the profession means that participants in the process can appeal to each other's common understanding of what this means for the young person in their care. It also means that if there is a difference, that this should be acknowledged and valued by all participants, and not just seen as a barrier.**

**In terms of organisational subcultures, the perspectives of practitioners, may be very different. Two aspects of perspective, are the focus and the object of the work. In both cases, the object of the work is the child or young person. This serves as a powerful meeting point. However, it could be argued that the *focus* of the work is quite different. The focus for the residential worker is the day to day care and control of the child and young person. For the nurse, the main focus is illness and disease, and their prevention. In this analysis, there are many areas of potential conflict about priorities or about how to best meet the child's need. Willumsen and Hallberg (2003) in their study on inter-professional collaboration in residential child care alluded to this when they noted that:**

***The professionals working closest to the young person i.e. those working in the residential institution, seemed to be most engaged and felt most responsible for the young person. More distant professionals were inclined to wait and see.***

**(2003: 396)**

**What is required is a clear understanding that practitioners from different professional groups will have different perspectives, which need to be understood and respected, but which also need to be reconciled if agreement on a care plan is to be achieved. The key to positive inter-professional practice lies in maintaining the young person at the centre of practice, whatever the field may be.**

**One of the most important messages for all professionals to take from an analysis of the constituents of organisational culture is to always recognise and build upon the areas of commonality and to try to understand and respect differences. It is argued quite strongly that a degree of insight and self awareness into the organisational culture of other professional groups and a willingness to use this knowledge in a proactive way will assist in inter-professional practice.**

**Activity 2 : Case study**

**Objectives : Participants will**

- **Examine a case vignette**
- **Identify ways that organisational cultures can clash**

**Consider the following case scenario and think about the ways in which organisational cultures may clash.**

**You work at Oak Tree house, a local mental health unit. You are alerted by a teacher at the local school that Dayn, a 14 year old young person in your unit, has disclosed sexual abuse by his father which had taken place while on home leave at the weekend. The disclosure happened over lunch. The teacher has noted that the child is walking awkwardly and thinks there may a physical injury. The teacher demands that the child is taken straight to a hospital after school.**

- a. What perspectives may be at work here?**
- b. What problems might arise through the clash of these perspectives?**

- c. What common areas might be exploited as the platform for inter-professional practice?**

**Activity 3 : Understanding change in organisations**

**Objectives : Participants will**

- **Examine some wider aspects of change in health and social care organisations**
- **Reflect on how this can be helped when working on the borderline**

**Social and health services are in a constant state of change and flux. These changes can be due to policy decisions at government level, or to re-structuring or other decisions made at local level. Some of the changes have an impact on inter-professional practice.**

**There have been several different ways of conceptualising change in organisations. Most of the research would indicate that people are resistant to change. It shows that change is traumatic but, if**

managed well, can have positive impact on practice. One of the most enduring models for understanding the feelings associated with change is the seven stage model. This model outlines seven stages which are akin to grieving. The stages are immobilisation, minimalisation, depression, acceptance, testing, search for meaning and internalisation.

When taken in the context of inter-professional practice, it is clearly important to understand the feelings engendered by the process of change. Working in a collaborative way implies that the participants may have to make some changes in terms of their thinking and beliefs. Given the feelings identified above, it is important to ask three questions when any change process is being implemented:

1. Are the participants active or passive?
2. Does the proposed change alter their identity or sense of self?
3. Do the participants perceive themselves as winning or losing?

Research indicates that change is best received and is more likely to be successful when participants play an active part in the process. They must be given an opportunity to state their concerns and feelings, and to have these listened to. They also need to feel that their professional identity retains its integrity. Finally participants must feel that they are not losing anything in the transaction. All of this requires highly developed communication skills, not the least of which is empathy.

In inter-professional practice, if mental health professionals or residential practitioners are aware that changes are inevitable because of decisions being made, they should keep in mind the feelings engendered by change and the ways in which the participants in the change process can be brought along in the process. Almost as important is the need for both groups of staff to be aware for the impact that change is having upon them, and the repercussions this may have on their relationships with colleagues.

### **TASK**

**Imagine that you are a mental health practitioner in a child care review and it has been decided that a child (who is your client and who is currently in residential care) no longer needs the residential worker to attend school with them to support them. You are now discussing this with the residential worker. However, the residential worker was not at the child care review as he was ill. He is feeling aggrieved because he feels his views were not fully taken account of by manager of the unit who represented his service at the review. How might the residential worker feel about the support being withdrawn and how would you convey understanding of his position while continuing to support the decision of the meeting?**

***Some final points on organisations***

**Within an organisation such as a health board, an education department or a local authority, it is fair to say that some grass roots practitioners may only have a blurred and ill defined sense of what constitutes the complete organisation, especially the senior management structures that exist in the larger public services. Their experience as practitioners is defined by their immediate work group. It is sometimes just too complicated and time consuming for individual staff members to get to know the organisation a whole. While it is not suggested here that this is necessary, some knowledge about organisational structures and culture are of benefit. In reality, as the organisation grows, it splits up into smaller units which become more specialised. It is this smaller unit which constitutes the work group and it is this smaller unit which will now come under discussion.**

**Activity 4 : What about groups in organisations?**

**Objectives : Participants will**

- **Reflect on the characteristics of work groups**

- **Examine how this may affect inter-professional working**

**The nature of human life is that people tend to live and associate in groups. Human beings are fundamentally social creatures. Groups provide the social structure to life. They enhance experiences, help celebrate achievements and assist with difficult times. Groups of various kinds provide the context for life and in general, create a sense of community. In terms of collaborative practice, the key groups to consider are the work group and the inter-agency group. There are also a range of issues to be taken into account when viewing the other practitioner as a member of the group. Once again, it is outwith the scope of this book to provide a full analysis of groups and group process. However, we believe it is useful to have some insight into the power of groups, how they work, and to be able to understand some of the implications for collaborative practice.**

**In terms of collaborative practice, however, it is most important to understand group process. Group process is all about how groups work. It is argued that mental health practitioners and residential practitioners should have an understanding of group process because many of the forums, within which decisions about children are made, happen to be a group. For example, think about the number of professionals who may interact with a child and their family when they are coming into care or mental health services and the number of times they meet as a group to make decisions regarding the child's placement. Some of the meetings may feel comfortable and productive. However, some may feel quite tense, even though it may be the same group of workers and the same child being discussed. Some of the tensions and discomforts within the group may be related to group process. These feelings and behaviours are normal within group process but may lead to serious misunderstandings at an early stage. An awareness of group process may help practitioners and go some way to preventing these misunderstandings. It should be remembered that groups are dynamic systems. In particular it is important to understand how small groups grow and change, and how they embed particular beliefs into their ways of operating.**

**Group roles and their impact on collaborative practice**

**Within any group process there is an assignation of roles. Within this process, the members of the group take on roles, or are forced by the group to take on roles. Group members take on two broad types of roles within groups. These are task roles and social-emotional roles.**

***Task roles***

**Initiator: suggests new ideas or new ways of looking at issues**

**Information seeker: asks for more information or clarification**

**Coordinator: shows the links between different ideas and tries to draw subgroups together**

**Evaluator: tries to assess the values of decisions**

***Social-emotional roles***

**Encourager: encourages others to contribute**

**Harmoniser: keeps the peace and tries to find compromises**

**Gatekeeper: helps others into the discussion**

**Some of these roles are taken on consciously or may be ascribed by the group. The assignation of roles is necessary to allow the work of the group to proceed. In relation to inter-professional practice, however, the ways in which roles are ascribed or taken on by members should be monitored. For example, the decisions made about the child may depend strongly on which person has been ascribed or has taken on the role of initiator. If, for instance, the role of initiator is taken by the mental health practitioner, their views may take precedence over the views of any other professionals and may unduly skew the discussion, unless that person has a degree of insight into the fact that they have this role, and then works hard to ensure balance.**

**One other role to be aware of is the role of scapegoat. This role does not emerge in all groups, but where it does happen, it can be very destructive, both to the person who is assigned that role, and to the group's purpose. As the name suggests, the scapegoat is**



invested with all of the problems and issues of the group and then is blamed or excluded. This helps the group to avoid issues. It is important to think about the scapegoat as they are usually perceived to be the weakest or least powerful member of the group. For example, if the residential worker, as a representative of the unit, is blamed for the fact that the young person is outwith control, absconds from home leave, uses drugs or any other issue, then other professionals do not need to examine themselves, the contribution of their organisation or the larger social or structural factors at work.

Linked to this is the idea of the 'in-group' and the 'out-group'. Vernelle described these concepts and paid particular attention to the out-group. This is an important concept for inter-professional collaboration. The out-group is quite simply a group outside of your own group. The in-group will have its own set of attitudes and practices, which can lead to unfair judgements of anyone who is not a member of that in-group. This is closely tied in with the concepts of prejudice and stereotyping. Stereotyping is a process by which people attribute behaviour to another on the basis of a set of characteristics with no particular foundation in reality. A person can be stereotyped based on their membership of a work group. Prejudice is an attitude or belief which causes the person to make judgements without any rational basis. Following on from this, it is clear that work groups are forms of in-groups and will view each of the others as out-groups. An interdisciplinary group or meeting will have representatives from their own in-groups. Within any new group which is formed either for a long term or a short term purpose, there is likely to be some prejudice. Most people have more prejudices than they care to admit to and therefore, as individuals, can be unaware of these feelings which may only surface under pressure. For effective inter-professional practice to occur, the individuals in the group must be try to be aware of their prejudices, especially about other professional groups, and to discard these, or challenge them if they see them emerging unhelpfully as part of the group process.

### **TASK**

Think about a social worker, a residential practitioner, a mental health nurse and a teacher. Jot these titles down and list some of the stereotypical views of the groups. What barriers to inter-professional practice may arise because of these stereotypes?

*Comment on activity*

**Looking at the stereotypical views generated, it is easy to see how barriers to collaboration can arise if these go unchecked in an inter-professional group. Most of the time, if all is going well, people will not revert to stereotypes. However, if there is a problem or a difficulty (which can be expected often when working with vulnerable children and their families) and participants are under pressure, outcomes may be different !**

### **Inter group conflict as a barrier to collaborative practice**

**The final group process to keep in mind during collaborative practice is that of inter-group conflict. In public service provision, agencies are often in the position of having scarce resources, be they placements at residential or mental health units, special teaching facilities, number of staff or money to fund home care support for parents who need some assistance with their children. As such, some inter-agency meetings may have hidden agendas. For example, there may be a meeting to decide on the best placement for a child with autism. The mental health worker may argue that residential school X is best because it meets the child's needs most closely. However, if residential school X is more expensive than residential school Y, it may be that the decision is made to place the child in Y, albeit inappropriately. Everyone must be clear about scarcity of resources and recognise the true basis for decisions, and the fact that conflict may arise if all parties do not share a view about the significance of resource issues in a particular case.**

### **TASK**

**Write a short reflection on some of the issues raised for you by your reading here. What kind of organisation do you work in? Is it highly bureaucratic? How much autonomy do you have? Do you understand the mechanisms by which your organisation works? Has your organisation been through changes? How does it cope with change? How are staff supported to cope with change? How easy or difficult is it to implement change that you think is necessary? What kind of subcultures do you have? Who are your traditional 'out-groups'? What role do you tend to take in meetings? How aware are you of the effect of stereotyping, scapegoating etc? Keep a copy of the reflection for your portfolio.**

### ***Conclusion***

**Good inter-professional practice involves working together but it is not enough to accept that practitioners will simply be able to relate to each other as people in a seemingly logical way. Practitioners are part of their work group, their agency and their organisation. All of these factors will have an impact upon inter-professional practice and it is helpful for mental health practitioners and residential practitioners to understand some of these dynamics. It may seem difficult at times to surmount some of the issues that can arise when taking account of group or organisational factors. However, we would suggest that the two keys to good inter-professional practice in this instance are to keep taking account of the group or organisational forces at work, and to maintain the child at the centre of any work being done.**

#### **Activity 5 : Working under stress: defence against anxiety**

**Objectives : Participants will**

- **Read some material on organisational defence**
- **Reflect on how this affects their organisation**

**Read the following shortened version of a paper by Isabel Menzies Lyth. It is a classic paper on organisational defense mechanisms when working with people in a health care setting. Use the critical appraisal tool in Appendix One.**

**<http://www.moderntimesworkplace.com/archives/ericssess/sessvol1/Lythp439.opd.pdf>**

**What did you think of the paper? Draw out the main issues for you within your work setting. Do any of the aspects of defense against anxiety have a resonance with you when you are working with very troubled young people? If so, what can you and your organisation do about this.**

**Next steps and evaluation**

**Can you please complete the evaluation form at the end of this handbook?**

## **APPENDIX ONE**

### **Critical appraisal tool**

#### ***(1) INTRODUCTION***

**If the paper has an introduction or an abstract, what are the aims of this paper ?**

#### ***(2) CONTEXT***

**What type of paper is this? Is it a research paper, a summary, a report, a review or something else?**

**What geographical and health/care setting is the paper addressing? Over what time period is the paper addressed? How recently was the paper published?**

#### ***(3) ANALYSIS***

**Give a brief outline of the summary or recommendations of the paper. What are its key aims? What data collection methods or sources of information were used in the paper? How wide or selective were the sources? How well is the analysis laid out? Are arguments clear? Is there clear evidence for any statements made? Are recommendations or conclusions valid and reliable given the information collection?**

**If it is a research paper, is the research methods adequately described? How were the data analysed? How adequate is the description of the data analysis? Are the findings interpreted within the context of other studies and theory? What was the researcher's role? Are the researcher's own position, assumptions and possible biases outlined?**

**What are your own views about the paper? What have you learned and what could be clearer? Have you any unanswered questions as a result of reading the paper? What could have been done better?**

#### ***(4) POLICY AND PRACTICE IMPLICATIONS***

**Implications: To what setting are the paper's findings generalisable? To what population are the paper's findings generalisable? Is the conclusion justified given the analysis and the information gathered? What are the implications for policy? What are the implications for service practice?**

### **References**

**Scott, T., Mannion, R., Davies, H., & Marshall, M. (2003). Healthcare Performance and organizational culture. Oxford: Radcliffe.**

**Vernelle, B. (1994). Understanding and using groups. London: Whiting and Birch.**

**Waterman, R.H. and Peters, T.J. (1982) In search of excellence. London: Harper Collins**

**Willumsen, E. and Hallberg, L. (2003). Interprofessional collaboration and young people in residential care: some professional perspectives. Journal of Interprofessional Care, 17(4), 389–400.**

**Evaluation form**

**Module three : selfstudy /e-learning**

**Can you please provide some comments on the following:**

<b>The handbook</b>	
<b>The methods used (self study, reading etc)</b>	
<b>Tutor support if needed</b>	
<b>Content of the module</b>	

<b>Standard of work expected</b>	
<b>What you had to do for your portfolio</b>	

***Module three***

***Inter-professional issues and collaboration***

***Part three: Work shadowing placement handbook***





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**Introduction**

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**Section Two: The placement**

**Section Three: Post-placement reflection and international work**

**Evaluation form**



***Introduction***

**Welcome to this handbook. It contains information and instructions on how to prepare and complete your work shadowing placement. For this placement you will be working in another workplace alongside the inter-professional partner with whom you have been working on the course. You will be shadowing your partner, who is from another professional group.**

**The placement consists of some placement preparation time, a three day placement in another agency and some time after the placement to compile your work shadowing report, during which you are asked to highlight a piece of good practice.**

**All of the material you need for your work shadowing placement is contained in this handbook and within the agency you will be shadowing in.**

**The aim of the placement is to allow participants to experience what daily work is like for their counterparts on the course.**

**The objectives of the placement is:**

- To familiarise participants with another style of work with young people**
- To examine the systems and structures of another workplace in practice**
- To reflect on the similarities and differences in reality between work styles with young people**
- To appraise the systems of work and how they reflect theory**
- To highlight good practice and indicate opportunities for inter-professional practice**

***Section One: Pre-placement preparation***

### **Pre-placement preparation**

As part of your course you will have been working in an inter-professional pair. Before the start of the course, your tutors will have made sure that it is understood that the agencies participating on the course will be welcoming a professional from another specialism into their workplace for 3 days. During the months before your placement, you will have been matched with a professional from a different agency. As part of your pre-placement preparation today, you will be expected to work with your partner from the other agency and organise the best time for the placement to happen.

Here is a list of the responsibilities of each partner in pre-placement preparation

*The course tutors will:*

*Obtain a signed agreement from all agencies taking part in this course that the agency will welcome a participant for a 3 day block placement.*

*Obtain a signed agreement that your agency will release you for the 3 day block placement with no loss of wages for you.*

*The tutors will have identified your partner and the agency which you will be going to for your block placement by the start of the first face-to-face day for Module Two.*

*Write formally to the placement at least one month before to confirm the identity of the participant, the dates of the placement and provide contact details and protocols for any problems which may arise.*

*The participants will:*

*Work with their partner from the agency in which they will have their work shadowing placement and find out as much as they can about the placement, using the template overleaf*

*Make initial contact with the host agency 3 weeks before the placement to negotiate the exact dates of their placement and give these dates to the course tutors.*

*The agency will:*

*Sign an agreement to host a participant from the course*

*Let the participant know of any health and safety or other protocols which need to be undertaken BEFORE they start the placement*

**Description of placement**

**This is part of your pre-placement preparation. For this you should talk to your partner whom you will be shadowing on the placement. On this sheet, write a description of your placement, using the following headings:**

**Name of agency:**

**Location:**

**Staffing:**

**Number of young people served:**

**Remit of the placement:**

**Protocols for multi-professional work:**

**Any other issues or questions which you need to clarify before going on the placement**

***Section Two: The placement***

## **Programme for the placement**

The placement will be a block placement and you will be shadowing one of your colleagues on the course. In preparation for the placement, all appropriate permissions should have been negotiated. Your tutor will have spoken to the group about this on your last face-to-face day.

This handbook contains three blank reflective writing sheets. It also contains a copy of the THL Finland model for describing best multi-professional practice. Use this model as the basis for your report to describe a piece of good multi-professional practice that you have seen.

Here is a list of the responsibilities of each partner during the work shadow placement:

*The course tutors will:*

*Provide contact details for themselves during your placement should any issues arise which you need to discuss*

*The participants will:*

*Attend the placement at the agreed times, shadow their partner in their host agency and work under their guidance and instructions*

*Complete one reflective account of practice each day*

*Make themselves aware of any agency protocols relating to health and safety*

*Alert the course tutors if there are any issues which arise during the placement.*

*The agency will:*

*Ensure that the participant's partner and fellow course member has all the resources needed to let them be effective supports to each other during the work shadowing placement.*

*Allow the participant from the other agency to have access the same experiences as those of the employee who is being shadowed.*

*Alert the course tutors if there are any issues which arise during the placement as per agreed protocols*

## Reflecting on practice

In this placement, you will be asked to do 3 pieces of reflective writing. You should write one account for each day of your placement. Choose a different piece of practice every day. Use Gibb's model, as we discussed in your orientation day. Just to remind you, the model is represented in the diagram below:



Gibbs G (1988) *Learning by Doing: A guide to teaching and learning methods*. Further Education Unit. Oxford Polytechnic: Oxford.



## **Reflective log 1**

**Description**

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

**Action Plan**

## **Reflective log 2**

**Description**

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

**Action Plan**

**Reflective log 3**

**Description**

**Feelings**

**Evaluation**

**Analysis**

**Conclusion**

**Action Plan**

**Work Shadowing Report using the THL Finland Good Practice Model**

**During your placement, you will have looked out for an example of good multi-professional practice. When you see it, discuss this with your shadow partner. If you agree on this, then use the THL Finland model as the basis for your work shadowing report for describing the example of good practice. This is important because it allows you to analyse in some depth the essence of**

good multi-professional practice and it will form the basis of your feedback to the wider group when you next meet. The details of the model are given below. When you write your report, use the model headings.

#### ***A. Basic information about the practice***

- Give the practice a brief descriptive name
- Specify the area of the social and health sector the practice relates to
- Specify what type of action the practice consists of (preventive action, early support and intervention, corrective action/rehabilitation, other)
- Describe the practice and its purpose with a few sentences (the practice in a nutshell).

#### ***B. How the practice is implemented***

The practice is described concisely and fluently based on the following elements:

- Actors: Describe all the actors of the practice and what kind of knowledge they should have. (The actors might include for example client, pedagogue, social worker, health professional, family member etc)
- Resources: Specify the resources that have to be mobilised when implementing the specific practice. (Resources might include for example certain tools, facilities, theories or working models. It is not necessary to describe the basic resources for work in social and health care.)
- Process, that is, the operational aspects of the practice: Specify the different phases of the practice and describe the kind of activity they require from the actors. (Activities by clients might include for example a certain kind of activity and a certain attitude. Activities by social and health care professionals might include the mobilization of various working methods and models, norms, theories and other resources. Activities by clients' family or friends might include ways to participate and ways to support family members/clients.)

#### ***C. How the practice has been evaluated***

Here it is specified what type of information has been collected about the functionality and/or effectiveness of the practice. It can be such as:

- Professional knowledge (documented views, experiences and perceptions generated in social and health care practice and collected as recorded by workers themselves or through group interviews, questionnaires etc.)
- Client/user knowledge (clients' or users' own experiences, views and perceptions of the practice that can be collected during client work or through group interviews, questionnaires etc.)
- Researcher's/ evaluator's knowledge (knowledge produced using various evaluation or research methods), or
- Other knowledge, what?

Describe also:

- Time, phases and methods of information collection
- What the information collected about the functionality and effectiveness of the practice indicates (positive and negative findings)

#### *D. How the practice has been developed*

Under this item, it is specified:

- What the process of development was like that gave rise to the practice (goals, phases and context, as well as actors and their roles)
- What advance assumptions there were about the effects or effectiveness of the practice (e.g. a programme theory); the assumptions can relate to for example the positive/negative or direct/indirect effects of the practice
- How the client's perspective has been taken into account in planning and implementing development activities.

For more information see <http://www.sosiaaliportti.fi/en-GB/goodpractice>

Your reflective logs and your description of practice will form the basis of part of the discussion in your groupwork on your next face-to-face day. So remember to put them into your portfolio and bring them with you to the next meeting !

***Section Three: Post-placement reflection and international work***

### **Post-placement reflection**

**This reflection will take place after all of the participants have been on placement and shadowed their partner professional and will be part of the final face-to-face day.**

**During the reflection, each of the pairs of partners will give a short feedback about what they learned about young people, what they felt to be the chief barriers to practice, and to present their model of good inter-professional practice to the group.**

**Once the group has given its feedback, a short paper (two pages long) should be drafted by the group for the online platform outlining the following for their country:**

- The main similarities and differences between the young people with whom they worked**
- The main barriers to inter-professional work**
- How systems and structures of work contributed to or hindered inter-professional work, in terms of bureaucratic processes and organisation issues**
- The main characteristics of good practice in inter-professional work which emerged from their discussion of the good practice case studies.**

**Once the group agrees that this is what they agree upon, this paper will be put onto the online platform**

**Finally each participant should complete the placement evaluation at the end of this manual.**

### **Placement evaluation form**

**Can you please provide some comments on the following:**

<p><b>Name of the placement</b></p>	
<p><b>Can you comment on how you found the process of setting up the placement?</b></p> <p><b>What could be better?</b></p>	
<p><b>Can you comment on how well the placement gave you access to information and opportunities to view practice?</b></p> <p><b>What could be better?</b></p>	



<b>How did you find the work that you were expected to do for the module?</b>	
<b>Did you need to contact your tutor about anything? If so what?</b>	
<b>Any other comments?</b>	

***Module three***

***Inter-professional issues and collaboration***

***Part four: Final synthesis, evaluation and preparation for National Seminar***



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**Activity two: Our ideas for good inter-collaborative practice**

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**Activity five: Warm up after lunch**

**Activity six: Preparation for research and development report and  
the National Seminar Day**

**Activity seven: Course evaluation**

**Activity eight: Unfinished business and endings**



## ***Introduction***

**Welcome to this handbook. It consists of a series of activities which will allow you to reflect on this course, continue the consolidation of your learning and evaluate the course so that future groups may learn from your experience.**

**The final synthesis and evaluation is important as it will also be the final meeting of your group. It is helpful to close any experience in a positive way and this will be your opportunity to express any final thoughts and feelings with regards to the course**

**It will also serve as the basis for your research and development report which you will have the opportunity to present at the National Seminar Day.**

**The aim of this final face to face day is to reflect upon and evaluate the course, and prepare for the National Seminar Day**

**The objectives of the module are:**

- **To have an open and honest discussion about what the impact of the course has been**
- **Reflect on how it has changed practice and collaboration**
- **Develop the research question for your research and development report**



**Programme for the day**

- 9.00 – 9.30: Arrival, registration, ground rules and introductions**
- 9.30 – 10.30: Our ideas for inter-professional collaboration**
- 10.30 – 10.45: Break**
- 10.45 – 11.30: Evaluation of the group process**
- 11.30 – 12.15: Training needs analysis**
- 12.15 – 1.15: Lunch**
- 1.15 – 1.30: After lunch re-energise**
- 1.30 – 2.30: Preparation for research and development report and  
National Seminar Day**
- 2.30 – 2.45: Break**
- 2.45 – 3.15: Course content evaluation**
- 3.15 – 4.00: Unfinished business and ending**



**Activity 1 : Arrival, registration and introductions**

**Time to complete the activity: 30 minutes**

**Objectives : Participants will**

- **Feel comfortable in the training**
- **Get an opportunity to have some fun**

**Your tutor will lead you through an introductory activity. The key point is to ENJOY this !**



**Activity 2 : Our ideas for good inter-collaborative practice**

**Time to complete the activity: 60 minutes**

**Objectives : Participants will**

- **Share the good practice they saw on placement**
- **Draw together ideas from this for the international colleagues**

**During the placement, participants were asked to write a work shadowing report using the THL Good Practice model.**

**Each of the pairs of partners will give a short feedback about what they learned about young people, what they felt to be the chief barriers to practice, and present their models of good inter-professional practice to the group.**

**Once the group has given its feedback, a short paper (two pages long) should be drafted by the group for the online platform outlining the following for their country:**

- **The main similarities and differences between the young people**



**with whom they worked**

- **The main barriers to inter-professional work in real situations**
- **How systems and structures of work contributed to or hindered inter-professional work, in terms of bureaucratic processes and organisation issues**
- **The main characteristics of good practice in inter-professional work which emerged from their discussion of the good practice examples**

**Once the group agrees that this is what they agree upon, this paper will be put onto the online platform**





### **Activity 3 : Evaluation of the group process**

**Time to complete the activity: 45 minutes**

**Objectives : Participants will**

- **Give some feedback to each other about how they have found being in the group**
- **Highlight any points which were positive**
- **Highlight any points which could have been better**

**A large part of this course has depended upon the group process and learning from each other. A variety of methods were used to promote this process. Your tutor would now like you to reflect and give some feedback on the part of the group process.**

- 1. First of all, you should work in your professional learning set and discuss how helpful this was and how it might have been improved. Focus also on what has been learned from your fellow professionals in the process. Note your points on the following page**
- 2. Now go into your inter-professional learning sets. Once again, discuss how helpful this was and how it might have been better. Focus on what has been learned from your colleagues from other professions. Note your points on the following page**
- 3. Now work in your pairs partnership with the person you shadowed on placement. Discuss how this was for each of you. Look at what was helpful and what could have been better. Once again, take notes on the following page.**



**After you have taken your notes, your tutor will lead a feedback session where participants can report on their discussions in the large group. Some feedback should also be gathered by the tutor on how the full group sessions went as process.**

**Professional group**

**What was helpful?**

**What could have been better? What could be done differently?**

**Key learning points from fellow professionals?**

**Anything else?**



**Inter-professional group**

**What was helpful?**

**What could have been better? What could be done differently?**

**Key learning points from practitioners from another profession?**

**Anything else?**

**Pairs partnerships**

**What was helpful?**



**What could have been better? What could be done differently?**

**Key learning points from your partner?**

**Anything else?**

#### **Activity 4: Training needs analysis**

**Time to complete the activity: 45 minutes**

**Objectives : Participants will**

- **Reflect on their learning for the course**
- **Begin to develop a training needs analysis for good inter-professional practice**

**A training/learning needs analysis (TNA) is a review of learning and development needs for staff. It considers the skills, knowledge and behaviours that staff need, and how to develop them effectively.**

**For this task you will be working in your inter-professional groups to come up with a range of at least 15 competences which you think are necessary for good inter-professional practice. Reflect on your learning on the course and on your experiences with each other and on placement.**

Once you have agreed on the competencies needed, note them on the grid below. Your tutor will take the grids and combine them, then put them up on the online platform. The grids for all the countries will then be analysed and combined to provide a grid for good inter-professional practice across Europe. This will be presented at the National Seminar day by your tutor and some opportunities for discussion will take place then before the Training Needs Analysis is finalised and opportunities for dissemination identified.

Training Needs Analysis



**Competences for good inter-professional practice with young people on the borderline**

Skills and knowledge required		WHY
<b>PRACTICE</b>		
1	<b>EXAMPLE: Co-ordinate service delivery</b>	<b>Because service delivery should not be duplicated or conflicting</b>
2	<b>EXAMPLE: Communicate with young people</b>	<b>Because all professionals need to understand what young people are saying so that they can be helped</b>
3	<b>EXAMPLE: Know the terminology used by mental health services</b>	<b>Because we need to develop a shared language</b>
4	<b>EXAMPLE: Know the services offered by local residential provision</b>	<b>Because we need to understand how a young person's needs are met holistically</b>
5		
6		
7		
8		

Skills and knowledge required		WHY
9		
10		
11		
12		
13		
14		
15		

**Activity 5: Warm up after lunch**

**Time to complete the activity: 15 minutes**

**Objectives : Participants will**

- **Feel comfortable in the afternoon session**
- **Get an opportunity to have some fun and waken up**
- **Reflect briefly on the morning and be introduced to the afternoon session**

**Your tutor will lead you through a warm up activity**



### **Activity 6: Preparation for research and development report**

**Time to complete the activity: 60 minutes**

**Objectives : Participants will**

- **Work on the research question for their research and development report: *Promising practice in my work***
- **Discuss the format of the National Seminar Day**

**An important part of the course is your Research and Development Report. The title of the report is *Promising practice for my work*. Working individually for 10 minutes, you should produce a mind map of an area of interest in the field of inter-professional collaboration which you want to research further and develop into a model of practice for your work.**

**A mind map is a diagram used to visually outline information. A mind map is often created around a single word or text, placed in the center, to which associated ideas, words and concepts are added. For your mind map, you may want to put a broad question about something that has interested you or concerned you during the course. For example, a question might be 'Why is it difficult to get quick referrals to our local**





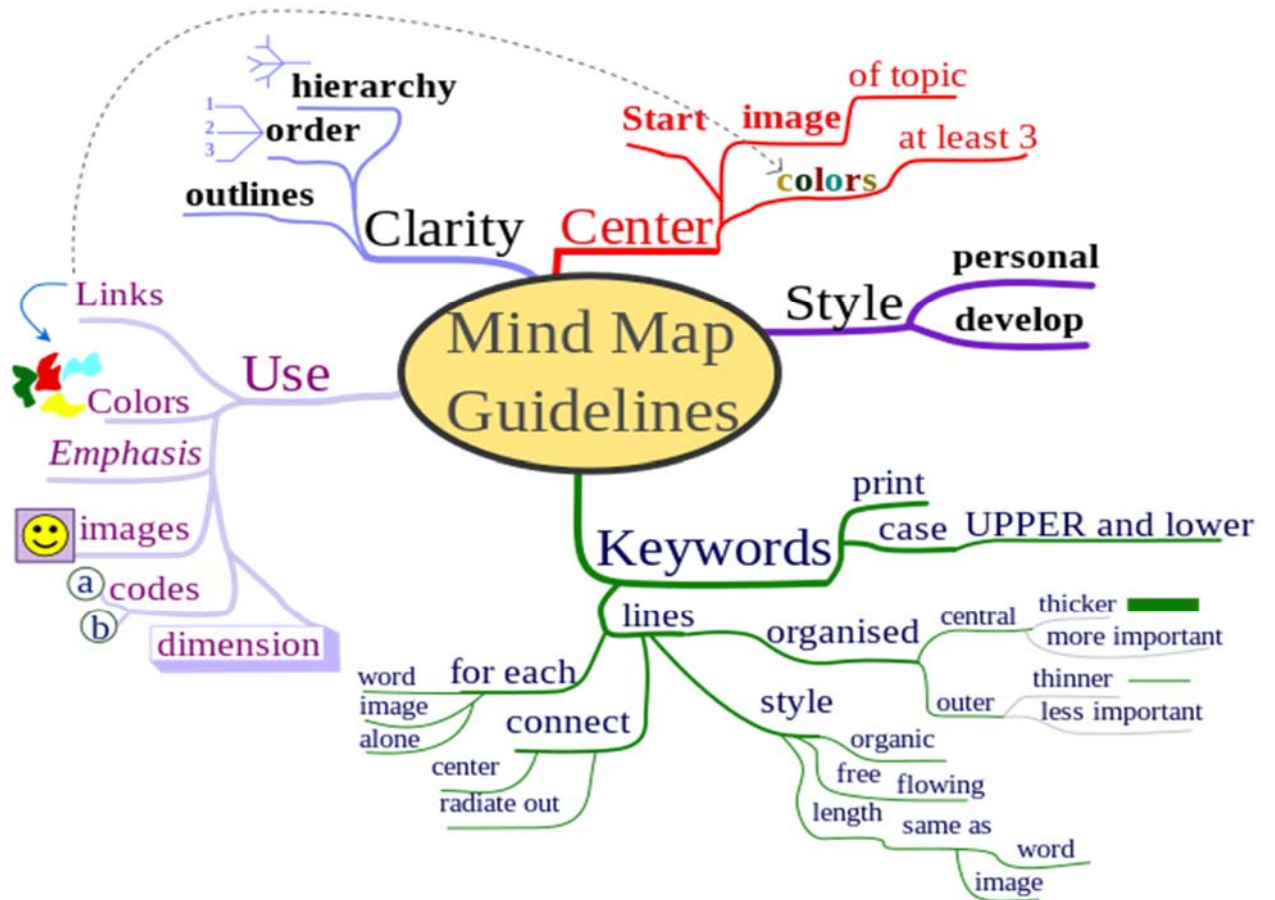
psychological services?’ When thinking of a question, remember to start the question with **WHAT, WHERE, WHEN OR WHY.**

When you have devised your simple broad question, major categories radiate from this central node, and lesser questions are sub-branches of larger branches. Categories can represent words, ideas, tasks, or other items related to a central question. See overleaf for an idea of how a mind map is constructed and what may appear in this.

Once you have completed your mind map, discuss this with your inter-professional partner and firm up your actual question. Your tutor will circulate around the pairs to make sure that the questions are relevant and clear enough for you to undertake your research and development task.

Example of a mind map with ideas you may wish to consider for your own mind map. Draw your mind map on the next page.





My mind map





**Now your tutor will help you to discuss the format for the National Seminar Day. For this part of the task, you will work in your inter-professional groups. Discuss what you would like to see in a National Seminar Day, the title of which will be**

**Working on the borderline: Improving inter-professional practice**

**Part of the seminar day should be given over to short presentations of your findings. Apart from this, work together and identify a possible structure, ideas for keynote presentations and ideas on how to include international perspectives. Each group should give some feedback to the tutor who will use this when it comes to organising and designing the National Seminar Day.**



## **Activity 7: Course content evaluation**

**Time to complete the activity: 30 minutes**

**Objectives : Participants will**

- **Receive a presentation on the feedback about individual parts of the course**
- **Have an opportunity to talk about the content, structure and methods of the course**

**By this time, your tutor will have gathered in all of the evaluation forms throughout the course and will give some feedback on what participants have said about each module.**

**Participants will then be led in a group discussion about what worked well on the course, what could have been done better, how the course was structured and hwat could have been better, and what they felt about the methods used on the course and how these could be improved.**

**This information will be gathered into an evaluation report and participants will be able to comment on this when it is completed.**



## **Activity 8: Unfinished business and endings**

**Time to complete the activity: 30 minutes**

**Objectives : Participants will**

- **Have an opportunity to discuss any unfinished business**
- **To take part in an ending exercise**

**When the course was designed, it was decided to leave a small amount of time at the end for discussion of any unfinished business. It may be that there is none ! However, if there is any unfinished business, it can be discussed now.**

**Finally, your tutor will lead you in an ending exercise. Sit in a circle. Your tutor will give each person a sheet of paper with their name at the top. The paper should be passed round. When it arrives with you, look at the name of the person and write at least one good thing that you will remember about this person at the bottom of the page. Fold the paper up so that the next person you pass it to cannot see what you have written. The next person should write something nice, fold it, and pass it to the next person and so on until it arrives back at the person whose name is on the top. Everyone can then read the things that their fellow participants have written.**

**Now the tutor will invite each person to say a little about what they have got out of the group on a personal level and what they will miss about the group. Group members will get the chance to give any comments about their tutor and give some feedback about how they have found the tutor as a person and as a facilitator of learning.**





