Room 3 – Ashley – AM
Chaired by Peter Reynolds
Northern Ireland Guardian ad Litem

6th Annual Social Work & Social Care Research in Practice Conference
Elaine Pollock
South Eastern Health and Social Care Trust
Risk Factors for Self-Harm: Narratives from a Sample of Young People in N.I.
Context for the Study

- Systematic Narrative Review
- Correlation between self-harm and suicide
- Focus on cutting behaviour
- 6271 persons presented to the 12 emergency departments in N.I, 2642 under 18 years (2012-2015)
- Figures are rising locally, nationally and internationally
- Age of onset between 14 and 24 years
- Literature relating to the perspectives of young people appeared scarce
Method

- Qualitative approach
- Semi-Structured one off interviews
- Up to 16 young people across the SEHSCT were invited to participate in the study
- Criterion for inclusion - open to social services, previously/ current self-harm through cutting, not in crisis, 16-18 years, not known to the researcher, able to consent, not in receipt of treatment, not open to any criminal investigation, not involved in any other research
- Ethical Approval
9 young people participated who met the criterion

Initially 14 young people agreed

Mix of male and female and one young person who did not identify

Eager to have their voices heard
Structure of Findings

Thematic analysis was applied to extract key themes from the information gathered (creating categories, exploring the relationship between categories whilst understanding the experience of individuals)

- Onset
- Persistence
- Ending

- Difficulties in support networks
- Exposure to self-harm
- Psychological issues
- Addiction to self-harm
- Hidden harm
- Support that helps or hinders
Difficulties in Support Networks

- Adverse Childhood Experiences (ACE’s)
- Peers relationships issues
- School issues
- Rejection, Bullying and Isolation
- Difficult developmental stage – vulnerabilities
“in school I was being bullied so I was, I had people you know calling me fat every day, telling me to go slit my wrists, hang myself, and that just built up and built up until eventually I just broke but and at home I didn’t want to take it out on my family so I took it out on myself which was then the self-harming”, (YP, F).

“my dad died when I was 10, and then, I started like hitting people, ....I kept getting suspended and then I was getting kicked out of school after school so I just started cutting myself to get like all the anger out,” (YP, G),
Exposure to Self-Harm Behaviour

- Through Friends or family
- Not a standalone risk factor - adversities
- Cutting as a coping mechanism
- Exposure increasing risk of persistence
“my mum used to self-harm and I used to like grow up with her like having cuts on her arms and things like that so I kinda thought it was like normal, like that was like a normal coping mechanism like cause she never talked to anyone, she never got help so she only like took it out on herself, so I kinda learned that from her”, (YP, C).

“I think my actual first exposure was actually Hollyoaks. Like you could visibly see it on the TV... you saw her cut herself emm in a kitchen sink, and like multiple, multiple times it happened”, (YP, D).
Psychological Issues

- Low self-esteem, unworthiness and self-criticism
- Punishment
- Releasing emotions
- Difficulty communicating, internalizing issues
- Experiences
- Sleep deprivation and substance misuse
“it make you feel, well obviously it makes you feel again but it brings you like you are back on earth, like you are just away and you are cutting because your minds messed up and it just brings you back”, (YP, F).

“people say you need to talk about it but what’s the point of talking about it if you can just about get through it in your head” (YP, I).
Addiction to Self-Harm

- Different aspects create the addiction – releasing emotion, pleasure, to see blood
- Cycle
- Normality
- Control vs Addiction
- Difficulty stopping
“I feel like it’s an addiction like, self-harm, it’s so stupid though it’s just like, you get sad then you cut yourself and then I regret it, and then I get sad so I cut myself and it’s just like on-going cycle”, (YP, B).

“No people do it, I’m trying to remember the name of it, I think it’s like endorphins, yeh people do it for the endorphins which eventually becomes an addiction to the endorphins but that’s not why I do it”, (YP, A).
Hidden Harm

- Sense of control
- Hiding cutting behaviour
- Not requiring medical treatment – self-assessed?
- Losing control - intervention necessary
“like I always felt that self-harming was like a control thing because like I’ve been in care since I was 8, like I’ve never had any control over my life, it was always like social workers or other people….. I think that’s why I stuck with it for so long even though I didn’t control it because it kinda controlled me”, (YP, B).

“Yeh, I just kept it to myself and didn’t tell anyone, like I probably needed stitches like but I didn’t go, can’t go to the hospital because it is written down and obviously if you are under 18 it’s sent back to the social workers”, (YP, H).
Support that hinders

- Lack of Trust
- Lack of consistency
- Relationship not built
- Unhelpful responses from family
- Peer support and commonalities
- Deep and Intrusive questioning
“like my family were kinda more negative towards it, like they said things like it was for attention”, (YP, I).

“no I didn’t like her because every time she tried to come see me, she used to try and hit the things that hurt the most, so I didn’t find that useful”, (YP, H).

“when I was getting like seen by professionals, I just felt like oh I’m just like another person out of like 100’s of other people that they have. It wasn’t like, I didn’t feel like they really cared about me, I just felt like, oh it’s another job to do, it’s just like something else to do, type thing”, (YP, C).
Implications for social work practice in N.I

- Assessment of risk and early intervention
- Practitioner creativity and timeliness
- Flexible services
- Self-harm - addictive behaviour – support service.
- Peer support groups or mentors, particularly those with direct experience of the behaviour.
- The quality of relationships
- Practitioners need to spend time listening to what those who self-harm say.
Future Research

- Wider and more diverse group of young people
- Mixed gender
- Younger age group
- Multiple encounters
- Other forms of self-harm
A Study of Health and Social Care Professionals’ Family Focused Practice with Parents who have Mental Illness, their Children and Families in Northern Ireland

Anne Grant, Susan Lagdon, John Devaney, Gavin Davidson, Joe Duffy, Oliver Perra, Karen Galway, Gerry Leavey, Aisling Monds-Watson
OVERVIEW OF PRESENTATION

- Acknowledgements
- Need for research on FFP
- Methodology
- Key findings
- Conclusions & recommendations
ACKNOWLEDGEMENTS

- The study was commissioned by the Health and Social Care Board who have lead the development and implementation of the Think Family NI approach.
- Thanks to those service users who helped us to refine our study protocol and particularly service user interview questions.
- Thanks to our Trust Principal Investigators & colleagues:
  - Adrian Corrigan (Southern Health and Social Care Trust)
  - Amanda Mc Fadden (Western Health and Social Care Trust)
  - Caroline Mc Gonigle (Northern Health and Social Care Trust)
  - Barney Mc Neaney (Belfast Health and Social Care Trust)
  - Don Bradley (South Eastern Health and Social Care Trust)
- Colleagues of Trust PIs = Mary Connolly David Douglas, Susan Mc Dermott, Deirdre Mahon, Valerie Devine, John Fenton, Lesley Walker, Kerry McVeigh & Michael Murray
- We are also indebted to a number of staff from both Adult Mental Health and Children’s service across each of the five HSC Trusts and their senior managers.
- Most importantly, we would like to thank all of HSC professionals and service users, who have taken part in the study.
Need for regional investigation of FFP

PMI is a Major Public Health Issue:

- Prevalence
- Impact
- Benefits of FFP
**KEY INITIATIVES**

Since the commencement of the Think Family NI programme in 2009 a wide range of initiatives have been developed and implemented.

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**Second phase 2013-2015**

- Communication and information sharing between professionals and families (aim was to develop information leaflets and the joint protocol)
- Access to early intervention family support for children, young people and their families (aim was to develop signposting/referral to hubs by adult mental health staff and ability of family support hubs to pick up on mental health and addictions issues for support)
- The extent to which assessment, planning and treatment is inclusive of a ‘whole family’ approach (aim was to promote use of the joint protocol in children’s and adult mental health services and to strengthen adult mental health documentation in line with The Family Model approach)

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**Key Initiatives from the first phase (2009-2013) of Think Family NI have included:**

- Development and circulation of educational resources to facilitate health and social care professionals and parents to talk to children about parental mental health problems.
- Staff development initiatives including training in family focused practice.
- Development of a regional joint protocol to facilitate joint working between adult mental health and children's social care services.
- Revision and amending of adult mental health screening and assessment tools (including an appendix for Understanding the Needs of Children in Northern Ireland assessment forms – see below), to include a focus on parents and child’s needs in relation to parental mental health problems.
- Development of an evidence based appendix to Understanding the Needs of Children in Northern Ireland, to strengthen and reflect upon parental mental health needs more robustly.
- Development of an aide memoire based on The Family Model (TFM) (A5 card), to encourage health and social care professionals to consider the needs of the whole family when parents have a mental illness and, or problematic substance use.
- Development of role and function of Interface Groups in each HSC Trust.
- Development of the Family and Staff Experience Sense Maker surveys. The methodology used was a qualitative approach which presented the qualitative data for analysis in quantitative format, identifying patterns and trends for analysis.

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**Most recently, ongoing key initiatives to improve services include:**

- Development of children and young people's leaflets by Action for Children young carers groups.
- Refinement of A5 cards checklist based on The Family Model (TFM) domains Falkov's (2012) that includes six questions (developed by service users and carers to support the family conversation).
- Introduction of a Think Family Support Worker practitioner in the South Eastern Trust and Belfast Trust and Western Trust.
- Evaluation of the SET Pilot and Think Family Support worker in SET.
- Development of an elearning resource on TFM, in conjunction with QUB and international partners from Australia and Norway to develop HSC professionals and service users’ awareness of the model and how it may be used in practice.
- Development of the Champions Model in the remaining four Trusts in line with developments in the Northern Trust.
WHAT DID WE DO?

There is an absence of studies comparing FFP across mental health and children’s services and limited evaluation of Think Family NI initiatives.

The study set out to measure:

1. The extent, nature and scope of HSC professionals’ FFP.
2. Factors that predict, facilitate and, or hinder FFP.
3. How FFP may be further promoted.
SURVEY ADMINISTRATION

A survey was distributed to approx. 3585 HSC professionals within adult mental health and children’s services across the five HSC Trusts to measure extent of FFP and predictors of FFP.

The total final sample of HSC professionals taking part in the current study (n) = 868

This number includes:

- Adult mental health (n) = 493
- Children’s social care services (n) = 316
SEMI STRUCTURED INTERVIEWS

Sample:
- 30 HSC professionals and 21 service users

Interviews were conducted to explore:
- The nature and scope of HSC professionals’ FFP
- Enablers and barriers of FFP
- Future potential developments in FFP.
INVOLVEMENT OF SERVICE USERS

- We involved service user representatives in an important advisory capacity working closely with the research team in key aspects of research design and methodology. For example, service users helped formulate wording of questions of interviews to be used with service users.
ADVISORY GROUP

- Advisory group - comprised representatives from the Health and Social Care Board, Health and Social Care Trusts, Research Team, a PPI rep and International advisor.
OBTAINING ACCESS TO PROFESSIONALS AND SERVICE USERS

- Research fellow contacted each of the Trust principal investigators (PI’s) with relevant information and instructions; this was then communicated with AD’s of Children’s services and AD’s of Mental Health services for circulation among team leads and HSC professionals.

- Process for obtaining access to professionals (workshops and online survey). PI in each Trust arranged for distribution of hard copies.

- Process for obtaining access to service users – Via PI in conjunction with support of Team leads and key workers.
## Role of PI in Each Trust

<table>
<thead>
<tr>
<th>Overall Project Support</th>
<th>PI’s and Team leads raised awareness of the study and promoted study activities</th>
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</thead>
<tbody>
<tr>
<td><strong>Workshops</strong></td>
<td>Assisted with arrangements of workshops including agreed times, dates and venues with respective Trust areas Promoted workshop attendance among HSC staff</td>
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<tr>
<td><strong>Surveys</strong></td>
<td>Circulated online and hard copy versions of the survey among HSC professionals and encouraged survey completion Reminded staff during data collection period to complete a survey and return to research team if needed</td>
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<tr>
<td><strong>Interviews</strong></td>
<td>Each Trust PI with the support of Team leads and Direct Care providers helped identify service users to take part in an interview</td>
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</table>
FACTORs ENABLING AND HINDERING ACCESS

- Factors that facilitated access:
  - Support of PI & professionals in each Trust who were family focused.
  - Detailed and clear communication protocol both in terms of study documentation and process for project team communicating with each Trust.

- Factors that hindered access
  - Complex governance process for each of the 5 Trusts – took ten months to get all five Trusts approval after ORECNI approval was obtained. Very difficult to access service users, particularly in a couple of Trusts.
  - PI required to complete GCP training
  - Honorary contracts and Access NI checks required to be issued for all project team members involved in data collection.
  - Breakdown of communication protocol within Trusts
  - Key workers did not always consider inclusion and exclusion criteria when inviting service users.
EXTENT OF FFP

- Overall, HSC professionals are not particularly family focused, with over half obtaining low scores on the majority of subscales in the questionnaire.

- Highest scores were obtained by Social Workers followed by Nurses and Psychologists. Psychiatrists consistently obtained the lowest scores across all subscales.

- A large majority of these high scorers reported practicing within community mental health teams (n = 105, 30%), or within family intervention teams (n = 73, 21%)

- The biggest difference between the high scorers and the rest of the sample related to skills and knowledge and referrals.
High scorers reported spending 50% or more in the service user’s home delivering services and more face to face contact with children whose parents have a mental illness compared to the remainder of the sample.

Compared with the remainder of the sample, Think Family Champions are more family focused. Think Family Champions ($n = 182$) had higher mean scores on all 14 FFP subscales.
### Summary of Significant FFP Predicators

<table>
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<tr>
<th>Dependent</th>
<th>Key FFP Predictor’s</th>
<th>Other Factors</th>
<th>Overall variance explained by predictors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing the Impact on the Child</td>
<td>Skills &amp; Knowledge</td>
<td>Gender (Female)</td>
<td>21.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Length of Time Practicing</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Age</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Length of Time Practicing</td>
<td></td>
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<tr>
<td>Connectedness</td>
<td>Co-Worker Support Training Skills &amp; Knowledge</td>
<td></td>
<td></td>
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<tr>
<td>Referrals</td>
<td>Workplace Support Time &amp; Workload Training Skills &amp; Knowledge Worker Confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventions to Promote Parents Mental Health</td>
<td>Time &amp; Workload Skills &amp; Knowledge</td>
<td>Child Focused Training</td>
<td>25.2%</td>
</tr>
<tr>
<td>Support to Carers &amp; Children</td>
<td>Time &amp; Workload Professional Development Skills &amp; Knowledge Worker Confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family &amp; Parenting Support</td>
<td>Time &amp; Workload Co-Worker Support Training Skills &amp; Knowledge</td>
<td>Child Focused Training</td>
<td>21.5%</td>
</tr>
</tbody>
</table>

Skills and Knowledge was noted as the single most important predictor. Such findings support the critical nature of skills and knowledge relating to PMI and its impact on children as particularly important for HSC professionals’ FFP.

Results also indicate that having less time and higher workloads has the potential to negatively impact on capacity for FFP.
Findings from Interviews

Overview of Two Thematic Networks

Societal Context

Nature and Scope of HSC prof FFP
- Principles of FFP
- Family focused activities & processes

Capacity to engage in FFP
- Enablers
- Barriers
- Future potential developments

Principles
KEY MESSAGES & RECOMMENDATIONS

- The findings suggest that while Think Family NI is a widely recognised initiative within some parts of the HSC system, the knowledge and understanding of FFP is more patchy.

- There are encouraging findings that indicate that some of the Think Family NI initiatives have supported FFP, in particular in relation to community versus in-patient services; children’s sector versus adult mental health sector; and the social work profession versus other professional groups.
However, there remains a large proportion of the workforce across all professions, services and sectors who display low levels of family focused awareness and practice. This is evident from feedback from both HSC professionals and, more significantly, users of services.

Whilst the Adult Mental Health and Children Services Joint Protocol aims to promote collaboration and a holistic approach towards service delivery, the findings suggest that this strategy is not effective to embed FFP and is hindered by a number of multi-level organisational and systemic barriers, including the co-occurrence of multiple adversities experienced by families when PMI is present.
The HSC Board should develop a Think Family NI Strategy and consider how this will be taken forward as part of the transitional arrangements for the embedding of Think Family NI within HSC Trusts.

In doing so it would be important to provide an overarching theory of change and the specific, intended outcomes for the overall strategy, and the associated elements.

The new Strategy should include an integrated plan for service development and guidance on how it should be implemented.
The Strategy should also include a governance and performance management framework. This will allow senior managers to monitor the implementation and effectiveness of the various initiatives under Think Family NI.

Each HSC Trust should formally adopt The Family Model (Falkov 1998, 2012) as the basis for future development of Think Family NI.

Finally, to enable researchers to undertake regional studies, the process for obtaining ethical approval could be streamlined to reduce the complexity and timescale to obtain access that is currently required.
Thanks for Listing
Final Reports Available @

Health and Social Care Board/ Publication Section
http://www.hscboard.hscni.net/

Children and Young People’s Strategic Partnership
http://www.cypsp.org/regionalsubgroups/think-family/

For Questions Regarding the Research Project Contact PI
Dr Anne Grant
Email: a.grant@qub.ac.uk
Effective Interventions with families, for adolescents at risk of entering state care

A Systematic Narrative Review
Laura Doyle
The Journey so far..

- Context of role
- Social Work Research
- Learning journey:
  1. Continuous professional development
  2. Service delivery service users/carers
  3. Challenge of synthesising experimental studies in social work
  4. Importance of completing systematic review’s
Contribute to this years conference theme & social work practice- Building research to evaluate complex interventions in social work and social care"

Focus will be research found on effective interventions with families for adolescents at risk of entering care

Opportunity for questions/ further discussion at end of presentation
Challenges facing children social care sector

- Higher number of adolescents in state care - As at 31 March 2018, there were 3,109 children in care. The number of children on the Child Protection Register in Northern Ireland at the end of March 2018 was 2,082, an increase from 2,061 in March 2017.

- 43% of looked after children come from the most deprived areas in Northern Ireland

- The problem is compounded by increasing complexity of need among the population of children who come to the attention of children services. Access to drugs has become a particular challenge.
Why this review is important

- Effective family support becomes more of a priority as does intervening early to prevent family difficulties escalating to crisis point.

- High costs of placement/ wider strategic context of finding innovative ways of working with adolescents on the edge of care – there is a need to reduce the numbers of children needing high-end, very expensive care, often on a repeat basis.
Methodology

Searching
- Rigorous search on 3 bibliographic databases (PsyInfo, SCIE, Social Services Abstracts)

Studies included
- Only Randomised Control Trials, Cohorts, Case Control methods

Data extraction
- 12 articles were extracted and a narrative synthesis undertaken
Two main interventions

- The evidence for the effectiveness of standardised intensive family support programmes seemed to be most robust in terms of reducing but not eliminating out of home placements, positive effects on placement prevention & maintaining adolescents in their own homes.

- There is a strong body of evidence, especially from the USA, but increasingly other countries, that MST is effective in both the short and the long term in reducing ‘out of home’ placements (Borduin, 1999, Henggeler et al, 2009b, Fonagy et al 2002)
Multi-systemic therapy (MST)

- MST is not suitable for all adolescents on the edge of care.
- Anti-social behaviour of the young person needs to be significant.
- Young people who are suicidal should be excluded.
- There is no evidence that MST is effective with those with severe developmental delays.
- For families who are struggling to look after their teenage child yet have managed to care for them throughout their childhood, MST is an effective evidence based intervention which can be deployed.
## Cost comparisons

<table>
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<tr>
<th>State care (UK – approximates)</th>
<th>Prevention interventions</th>
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<tr>
<td>Foster care – £33,000 per annum (Curtis 2012)</td>
<td>Adolescent support teams (£2,500 per young person (£135 a week)</td>
</tr>
<tr>
<td>Residential home – £156,000 per annum (Curtis, 2012)</td>
<td>MST £8,000–£12,000 per family.</td>
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*Note: These figures also reflect international findings, out of home placement in US are three times more expensive than community based interventions. In Israel four times more expensive (Miller, 2000, Schmid, 2007)*

### Benefits
- Significant savings will be made – preventing costly placements
- Reduce the need for future care placements
- Reduce additional costs to society including involvement with criminal justice process, or those not in Education, employment or training (NEET)
Implications for practice

1. Interdisciplinary/multi-agency approach
2. Respond differently to meet complexity and range of different needs (multi-modal approach)
3. Actively working to prevent crisis with adolescents and families rather than reacting to it
4. Relationship key theme through literature ‘who works’ (i.e. quality of relationship) as important as ‘what works’, (i.e. programs/models)
It is important to acknowledge adolescents are a dynamic group of service users and can flow through the continuum cycle at any one time depending on their individual needs and circumstances.
Would like to see:

1. The outcomes of the evaluations of local pilot initiatives for this cohort of adolescents
2. Increase research in social work on quantitative methodologies, with robust study designs
3. More research specific to adolescents, early intervention and family preservation
References