

“If I didn’t have them, I’m not sure how I would have coped with everything myself”:

Empowering and supporting parents/carers of high-risk young people assisted by

Community Forensic CAMHS

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Conflicts of Interest

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Parent/carer involvement in their child's support for mental health difficulties is a critical component of effective care. 13 Community Forensic Child and Adolescent Mental Health Services (F:CAMHS) across England were developed to provide specialist support to young people at high risk of harm to self and in particular others, and their families. The aim of this study is to explore parent/carer experiences of Community F:CAMHS. Thematic analysis of interviews (N=18, from 5 sites) was conducted. Superordinate themes generated focused on 1) facilitators; and 2) barriers to support. Subthemes generated relate primarily to facilitators, particularly empowering parents/carers through the co-production of strategies to help, "holding" cases (taking ownership), and acting on behalf of and supporting parents/carers. Managing clear, joined-up communication across multi-agencies is also of key importance. Barriers to effective support are a lack of joined-up communication at the beginning of the implementation of the services, awareness of Community F:CAMHS, and limited contact. Implications, including the need to further embed the Community F:CAMHS offering in the overall provision of support for this population are discussed. Areas for future research are identified, including the exploration of how young people's characteristics and outcomes may impact parents/carers' experiences of interacting with services.

Key words: Community Forensic CAMHS; Community F:CAMHS; children and young people's mental health difficulties; reflexive thematic analysis; parent mental health strategies

Children and young people (hereafter young people) who present with high risk of harm to self or others, have been consistently shown to have greater mental health and learning needs than their general population counterparts (Department of Health, 2009; Harrington et al., 2005). They are more likely to experience adversity, trauma and have complex needs (Department of Health, 2009; Lader et al., 2000), and have poor experiences of care provision and reduced life chances (Edmunds et al., 2018; NHS, 2016; Hindley et al., 2017). Across the United Kingdom (UK), there has been a recent shift in perspective, with a move towards a diversion from custodial settings to early intervention and community prevention (for example, the Child First Justice strategic objective in England and Wales; Case & Browning, 2021; and see Lightowler et al., 2014 for evidence in Scotland). At the time of writing, the number of young people up to aged 18 accommodated by the secure estate in England and Wales, is 586, which is a 28% decrease compared to the previous year (March 2020; 815). This decrease may have been due to the effects of the COVID-19 pandemic. Prior to this, the number was 920 in 2018/19, and 1,004 in 2017/18, constituting an 8% decrease (Her Majesty's Prison and Probation Service and Youth Custody Service, 2021). However, despite this decline over time, there is a continued over-representation of young people from minoritized ethnic groups in the Children and Young People Secure Estate (e.g., Lammy, 2017). Further, a recent meta-analysis of 30 international studies found a pooled prevalence of at least 66% of children accommodated by the secure estate have a diagnosed mental health difficulty (81% of males; Livanou et al., 2019).

Recent policy in young people's mental health, such as Future in Mind (NHS England, 2015) or the Five Year Forward View (NHS, 2016), has led to the implementation of new workstreams and programmes to improve service provision and early intervention efforts. As a result, 13 new Community Forensic Child and Adolescent Mental Health Services

(F:CAMHS) were commissioned by NHS England and NHS Improvement in 2018 (NHS England, 2017). Community F:CAMHS offer specialized support and intervention to young people (up to 18 years old) who are at high risk of harm to self and, in particular, others, as well as the systems around them, specifically:

“[young people] presenting with severe disorders of conduct and emotion, neurodevelopmental or serious mental health problems or where there are legitimate concerns about the existence of such disorders; usually involved in dangerous, high-risk behaviours towards others whether they are in contact with the youth justice system or not; in exceptional cases, are not high risk (not primarily dangerous to others) but have highly complex needs (including legal complexities) and are causing major concern across agencies”

(Irani, 2017, p.7).

The majority of young people who are seen by Community F:CAMHS are aged between 12 and 18 years (84.7%), with some younger. The majority of reasons for referral are violence or aggression (80%; Lane et al., 2021). Community F:CAMHS are widely spread across England; in the North (North East and North Cumbria, North West, Yorkshire and Humber), Midlands and East (East Midlands, East of England, West Midlands), South (South West North, South West South, South Central, South East) and London (North East and North Central London, North West London, South London). Recent research exploring the characteristics of young people referred to Community F:CAMHS has further highlighted high levels of comorbid difficulties, trauma and multiple disadvantage in this cohort and within their families (Lane et al., 2021). This research additionally stresses the significance of multi-agency and collaborative working in the care of young people who present with high risk.

The need for collaboration and communication between agencies in the commissioning and delivery of help for young people who have multiple needs, and their families, is

universally recommended in statutory guidance and practice guidelines across the different sectors (e.g., Ministry of Justice and Youth Justice Board, 2019; Department for Education 2018; National Institute for Health and Care Excellence, 2017; NHS, 2015). Yet serious case reviews in England regularly identify failures in collaboration and communication between agencies – particularly in cases characterized by significant complexity and risk – as contributors to serious negative outcomes (NSPCC 2017, 2021). In particular, the tendency for services to work in silos, with no one service having a complete view of the young person’s situation and the absence of an overarching plan have been cited as contributing factors. The unique challenge of effectively coordinating help – despite the best efforts of professionals involved – in the context of the complexity that arises when young people have multiple, interacting co-morbidities, high risk and the consequent involvement with multiple agencies, has been well documented (Ungar et al 2014, Bevington et al 2017, Almqvist et al., 2018). It is described as a “wicked problem” (Valentine 2015).

Further, the process of parental and carer help-seeking in the context of mental health services has been described as unclear and fraught with obstacles (Boulter & Rickwood, 2013). Most parents/carers have to link with more than one stakeholder agency with regards to their child’s care (Shanley et al., 2007), which often results in them being the conduit of communication and leading the cohesion between the agencies. Parents/carers have described the process of attempting to obtain support for their children as arduous, and a key barrier to engagement with services and finding the correct “fit” (Boulter & Rickwood, 2013). Additionally, research suggests that in most cases, parents/carers, in attempts to help with their child’s difficulties, have agreed to interventions that they favoured less than others (Shanley et al., 2007), which further highlights the importance of effective working and clear communication with parents/carers and families to find agreed ways forward. Parents/carers may find accessing support for – and trying to help – their child’s mental health difficulties and

high-risk behavior particularly worrying and stressful (Meltzer et al., 2011), underlining the importance of supporting parents/carers as well as young people. Indeed, parents/carers have identified the need for information in addition to the provision of emotional and instrumental support as key for their child who is experiencing mental health difficulties (Scharer, 2002).

Little is known of how parent/carer involvement occurs and is experienced when accessing support from services such as Community F:CAMHS. However, parents/carers are likely to be first to identify changes or risks in their child's behavior. Parent/carer information has been found to be valuable for assessing mental health difficulties in young people, and mental health professionals have been encouraged to draw on parent/carer contributions and perspectives when assessing young people's mental health (Aebi et al., 2017). Beyond this, parents/carers can play a central role in helping young people with mental health difficulties, and parent/carer involvement in their child's support for mental health difficulties is a critical component of effective care. Research suggests that when offering provision for behavioral difficulties, which may or may not include high levels of risk, in approximately half of cases interventions were directed towards the parents/carers (Haine-Schlagel et al., 2012). Much has been written on the importance of therapeutic alliance as a core component of effective child and adolescent therapy (Karver et al 2018). Whilst most research has focussed on the role of the young person-worker relationship, a similar association has been found between parent-worker alliance and outcome, where a positive parent-therapist relationship is significant to supporting continued engagement in treatment (Shirk et al 2011). Whilst this research relates to therapy settings, rather than the structure of co-ordinating help for high risk and high harm young people, there is evidence that the role of parent/carer empowerment is key when helping families who have similar challenges faced by those seen by Community F:CAMHS. For example, research suggests that family empowerment is a mediator of family-centred support

and positive outcomes (Damen et al., 2021; Graves & Shelton, 2007) and good parent-therapist relationships facilitate positive outcomes (Lamers et al., 2016).

Parenting interventions are widespread across the UK, for example, with the rollout of the Parenting Early Intervention Programme (PEIP) between 2008 and 2011, which consisted of funding for all Local Authorities in England for the implementation of evidence based parenting programmes, (Lindsay & Strand, 2013), and Multi-Systemic Therapy (Henggeler et al., 2009) and Non-Violence Resistance (Omer, 2021), multi-modal systemic, family and community-based interventions commonly implemented for adolescents. However, Community F:CAMHS seek to provide a more whole-systems approach to supporting families, rather than being a structured parenting programme. Community F:CAMHS input consists of carefully gaining key information (particularly in relation to risk and mental health) from the young person, their parents/carers, and the multiagency professional network that surrounds the family, in order to inform forensic mental health risk assessment and risk management planning. Given the unique nature of this type of support to the families of young people who are at considerable risk of harm or for whom there are elevated concerns about, and the associated dearth of research into the experiences of parents/carers who are supported, the aim of this research is to explore parent/carer experiences of Community F:CAMHS to support them in the care of their children. In addition to this overarching purpose, more specific objectives include the exploration of the practicalities of Community F:CAMHS work with parents/carers; to determine what is and is not helpful, with a view to furthering knowledge in this area, and making wider recommendations for policy and practice. The key audiences for this research are clinicians and policy makers working with this population.

Methodology

Research design overview

Participants were involved in a wider national mixed-methods Realistic Evaluation (Pawson & Tilley, 1997) of Community F:CAMHS in England, commissioned by NHS England and NHS Improvement, between 2018 and 2021 (NHS England, 2017). The interviews discussed have been reported in the final evaluation report submitted to the funders, but the findings pertaining to the research question outlined in this research were unique to this study and have not been reported elsewhere. A qualitative design was chosen to allow in-depth exploration of experiences and nuances of support provided to parents/carers to help their children. Interviews were chosen to ensure participants were able to freely disclose their experiences and not constrained by closed questionnaire or survey questions. A qualitative research design was appropriate as it facilitates the testing of the depth, richness and complexity of relationships not otherwise possible. This design was also an appropriate fit to investigate the main purposes of the research: to describe the support provided, thus highlighting practice, to explore this as an element of social interaction, and to develop understanding of what is effective. The APA journal article reporting standards for qualitative research guidelines (Levitt et al., 2018) were followed.

All data analyses were theory driven, with topic guides and the first organisation of the data being based on a logic model developed based on existing theory and clinical experience (see, Lane et al., 2021). The logic model outlines who the intervention targets, what the intervention is, and more pertinent to the present research, the change mechanisms and outcomes. Specifically relating to change mechanisms, “clear set of support and confidence to manage risk” and “more effective help” are most relevant to the current study, and in terms of outcomes, all identified areas are relevant (“improved mental health and wellbeing”, “reduction of harm”, “reduction of risk/offending”, “improved social inclusion” and “improved education,

employment and training”). Whilst this study sits within a wider service evaluation, thus aiming to provide feedback to funders, this specific research exploration aims to further knowledge.

Telephone qualitative semi-structured interviews were conducted with parents/carers of young people referred to Community F:CAMHS between February 2019 and November 2020 ($N=18$). Interviews were held for between 3 minutes 38 seconds and 40 minutes 30 seconds, with an average interview time of 17 minutes 46 seconds ($SD=0.01$). The interview topic guides were created by the research team and steering group, for the overall evaluation of Community F:CAMHS (see Supplementary Material for sample questions). The sample size was determined to achieve diversity in views and perspectives so that we were confident that we were able to reflect similarities and differences across a range of experiences (Morse, 2000). The telephone interviews were audio recorded; data files were securely handled and transcribed ‘smart verbatim’ (where colloquial speech is included as spoken, e.g., “gonna” but elements of speech that add no content are omitted, e.g., “uhm”). All data analysis was conducted in the NVivo 11 qualitative software package (QSR International, 2020).

An inductive method of Reflexive Thematic Analysis (Braun & Clarke 2019; 2020) was used with themes generated through the analysis and organisation of the transcripts, in a process of open coding (Corbin & Strauss 2008). It was important to use an inductive method to explore the data, and to combine it with the deductive prior step of topic guide development. The composition of inductive data analysis with deductive topic guide generation, ensures that the findings of this research are data driven, and therefore retain the voice of the participants, remaining close to the context and supporting new theory as relevant, whilst also being grounded in existing theory at a higher level, which situates the research within the context of the wider evaluation. This is essential because it ensures the generalizability of the findings to this specific context, as well as providing a base to link back to the existing theory. One coder (JJ) coded all interviews, and the second coder (RL) coded approximately 25% of interviews.

Both coders had been previously trained in qualitative data analysis to Master's (RL) and Doctoral (JJ) levels, and were experienced in coding qualitative data. The themes and subthemes were subsequently shared with the rest of the research team for review.

Participants

Participants were recruited from five sites. Parents/carers who participated ($N=18$) had been in contact with Community F:CAMHS, where their child had been referred to the team due to high-risk, high harm behavior, or due to concerns about the young person and family. Within these settings, parents/carers were identified by staff to participate in a process of convenience sampling on a case-by-case basis, where it was deemed appropriate in line with the circumstances of each case. Parents/carers were subsequently inducted into the study by a member of the Research Team (SD, RL and others). No incentives or compensation was offered for participation. No demographic information about the participants was collected. Ethical approval was granted by the Health Research Association for the data collected from parents and carers (IRAS project ID: 242383; REC reference: 18/LO/1569). Informed consent was obtained from all participants. Identifiable details were de-identified at the point of transcription.

Methodological reflexivity

The epistemological positioning of the coders (JJ, RL) and all researchers, prior knowledge and exposure to psychological theories and the political and structural context of the services impacted the analysis and narratives in this research. The lead author's (JJ) pragmatist philosophy is such that the most appropriate research methods are those that fit the research questions, and areas of inquiry. This means that as a researcher, there are no specific ties to certain methodologies or analysis techniques, and as such a pluralism is adopted. This

is born out in the use of the existing framework used for the development of the topic guides, which spoke to the specific needs of the wider evaluation research questions and Realist approach, supplemented with further in-depth analysis of the interviews to explore the present research questions. However, the prioritisation of the voice of the participants through data driven findings is also important to the lead author and something that was emphasised in the analysis for the present research question. The coders were mindful of the potential tensions between this and the development of the topic guides through the logic model, and were conscious to remain open minded to deriving data driven results, whilst also acknowledging that Reflexive Thematic Analysis understands researcher subjectivity to be a resource which aids the generation of themes. Any interpretation differences between the coders were discussed, and converged, with this process of convergence implying enhanced accuracy and mutual understanding of the data (Madill et al., 2000). The varied experiences of the researchers are beneficial to the narrative and understanding of the data; more specifically, some researchers have research backgrounds (JJ, RL, SD, JEC) others have clinical backgrounds (RL, LC, OW); with overall experiences sitting within both forensic settings and wider CAMHS. These varied experiences and knowledge are essential to the full consideration and interpretation of the findings to this specific context, including discerning relevant clinical implications.

The Research Team's interactions with participants might have been influenced by their own identities, experiences, and prior assumptions. All data collection was conducted by two co-authors (RL, SD) and researchers in the wider team. The researchers were not known to the participants, and had not previously met other than a prior telephone call to arrange the interview time. The benefit of having not met the participants is that the interview interactions will not have been influenced by previous communication ensuring a level of consistency across participants. However, not meeting participants previously means that there is less time

to build a rapport and as such the participants may have felt less able to disclose difficult experiences in a way that they would have been able if they already knew the researchers. Nevertheless, the researchers were separate to Community F:CAMHS, having been commissioned to conduct an independent evaluation of the teams; this separation from Community F:CAMHS may mean that participants felt more able to disclose less positive experiences. Topic guides were developed by the Research Team and Steering Group as part of the evaluation project, but the experiences and prior views of the interviewing researchers may have been expressed in implicit emphases on questions.

Findings

Two superordinate themes were generated from the interviews: “Facilitators to Support” and “Barriers to Support”. The superordinate themes were further organized into six subthemes.

1) Facilitators to support

Clear, joined-up communication

Six parents/carers discussed the facilitative nature of clear and joined-up communication. Specifically, parents/carers expressed that good levels of clear communication from Community F:CAMHS enabled them to feel supported in their own care for their child’s difficulties. At times, this was in relation to providing prompt and clear communication, for example: “*he [Community F:CAMHS clinician] always replied. And he was very prompt in supporting us [...] he always included me in emails*” (Parent/Carer 6). Other times this was described as Community F:CAMHS being the linkage between multiple agencies involved in the child’s care, which often highlighted the importance of joined-up communication between the parents/carers and educational settings, for example: “*[Community F:CAMHS clinician]*

also [...] spoke to the school. So, it wasn't just me they were talking to, it was getting everybody involved in it, and that worked so much better" (Parent/Carer 5); *"It was good communication right across the board"* (Parent/Carer 10) and *"[...] they've helped coordinate with us and the school"* (Parent/Carer 7). Parents/carers also discussed the quality of the communication, which they described as clear and of high impact, for example: *"[...] at last somebody was giving us some information back and telling us it straight"* (Parent/Carer 7).

Being able to support parents/carers and young people in a multi-systemic way is crucial to positive outcomes (see, Tan et al., 2017; Timmons-Mitchell et al., 2006; Ungar et al., 2020) and good- and joined-up communication is essential to the effectiveness of this support. By providing good and consistent levels of communication, parents felt as though they were being supported, and that progress was being made. International applications here pertain to the suggestion that consistent and joined-up communication is crucial to the delivery of effective multisystemic support to young people and their families. This is particularly pertinent when considering populations who are at high risk of harm, and are often being supported by multiple agencies, but who also may "fall through the gaps" due to disconnections in provision, and if communication is not effective between agencies (Hindley, 2013).

Co-production of strategies and practical advice

Eight parents/carers said that Community F:CAMHS worked with them to devise co-provided strategies, as well as offering them practical advice about next steps. In terms of co-provided strategies, this was often related specifically to strategies that parents/carers could utilize to help them manage their child's difficulties, or the difficult family situation, often described as coping strategies, and they: *"[...] gave us direction"* (Parent/Carer 7); for example: *"they also gave us a plan for [child], which we're still following at the moment, with strategies on how to cope with her, for her safety, and also to help us"* (Parent/Carer 12) and

“So now I can go about things a little bit differently [...] approaching situations at home differently for both of us, [...] has helped the situation” (Parent/Carer 4).

In terms of advice, this was related to Community F:CAMHS providing practical advice to the parents/carers in the form of information leaflets, helplines and support groups and recommendations, for example: *“there was sort of a recommendation about the type of support that he needed, like residential school at that time [...] supporting us with suggestions of what type of place, what type of school, what type of support”* (Parent/Carer 7). This was often described as providing direction to the parents/carers to help them support their child, for example: *“he [child] can now see that forensic CAMHS are actually starting to make a difference in helping us to help him”* (Parent/Carer 15). At times, parents/carers described feeling empowered to make decisions that they were not able to before, based on the practical advice from the team, for example: *“I feel like we’ve been empowered by the team around us to go, you know what, actually we don’t need that, and that’s okay”* (Parent/Carer 7).

These findings highlight the importance of providing ways in which parents/carers can be empowered to support their child. This is not via the traditional route of parent training programmes, but rather by provision of signposting to additional resources, supporting the development of new ideas and different ways for parents/carers to help their child. The type of information provided to parents/carers to support their child’s mental health and wellbeing has been demonstrated as varied depending on professional type (see, Cunningham et al., 2009), suggesting the need for more consistency. International applications here pertain to the specialised and individualised nature of the support in the context of this high risk group of young people. This is linked to previous key research that parents/carers have identified the need for information in addition to the provision of emotional and instrumental support as key for their child who is experiencing mental health difficulties (Scharer, 2002).

Facilitating understanding

Four parents/carers said that input from Community F:CAMHS increased their understanding of their child's difficulties, which in turn helped them to feel more supported; for example: *"when they got involved and we started to understand a little bit more, and I felt a bit more supported"* (Parent/Carer 7) and *"It was just like a jigsaw puzzle that just went, 'Oh my God,' and she [Community F:CAMHS clinician] explained things to me and how to... like sort of explained it to [child] first. So, I got a lot of understanding from it"* (Parent/Carer 13). Further, parents/carers discussed how a better understanding of their child's difficulties enabled their situation to feel less overwhelming; for example: *"nothing feels daunting any more. Whereas I think before F:CAMHS got involved, it just felt very frightening and overwhelming, and we really didn't have the answers"* (Parent/Carer 14).

Parents/carers described input from Community F:CAMHS as being open-minded and without prejudice: *"[...] and they never judged me"* (Parent/Carer 5). Parents/carers said that the sense of understanding was twofold, i.e., they felt that both they and their child were being effectively heard and understood; for example: *"it definitely feels like, 'Yes, I hear you' [...] we could never have got to that stage without someone saying, 'Actually, we're listening to you. We're hearing what you're saying. And we think this is what your family needs'"* (Parent/Carer 7).

The implementation of a child mentalization-based models may contribute to increased positive outcomes for vulnerable children (Oehlman Forbes et al., 2021). Helping parents/carers to better understand their child's difficulties is key to a mentalization process, a better understanding themselves of the mechanisms underpinning behaviour, and additionally but crucially, this helps parents to feel less overwhelmed with their child's difficulties and the challenges that family may face. Parents/carers have previously discussed feelings of personal

or family guilt or shame in relation to their child's mental health difficulties (see, McDonald et al., 2007), as well as self-stigma leads to a diminished sense of being a good parent (Eaton et al., 2016). Therefore, non-judgemental support to parents/carers is essential in helping them to minimise, process and dissipate those feelings. Negative emotions experienced by parents/carers in relation to their high-risk young people are not specific to the UK and may be more apparent in some cultures more than others (e.g., Gilbert et al., 2007; Yakeley et al., 2018).

“Holding” the case, or acting on behalf of parents/carers

Eight parents/carers said that they experienced input from Community F:CAMHS as having a role in “holding” cases. This is closely linked to joined-up communication, which was described as being the central contact overseeing the multi-disciplinary work of the various agencies involved. The efficacy of this approach was typically delivered by Community F:CAMHS remaining present and acting from a place of authority and ownership of the case, for example: *“We were in limbo land, no one wanted to take that ownership and decision and responsibility of how we went to the next level. Because we had lost the police interaction and guidance, so we needed somebody there that would give us that”* (Parent/Carer 15) and *“Because our case is very complex, he [Community F:CAMHS clinician] then dealt with the wider circle, so everyone felt that they could contact him to help with everything”* (Parent/Carer 3). Other times this was expressed in a sense that Community F:CAMHS clinicians were working on behalf of the parents/carers. For example, *“they [Community F:CAMHS clinicians] chased that on my behalf without me having to go to school and say, ‘All right, can you give me the information, or can you email it to CAMHS?’”* (Parent/Carer 2) and *“[the Community F:CAMHS clinician said] ‘I will give them the case file and provide them with everything they need to know, so you don’t have to go through it’”* (Parent/Carer 7).

“A named linked person” has been shown to be key to the facilitative nature of interagency collaboration, with poor communication identified as a significant barrier (Cooper et al., 2016). Further, the same international systematic review found that such interagency collaboration was identified by parents/carers/children and professionals as being helpful and important. This emphasises the importance of effective, joined-up communication, via the input from a specialist clinician who takes a leading role in the coordination of appropriate interventions and support across multiple agencies. The Independent Review of Children’s Social Care in England has identified an “accountability gap” (2021), in which the needs of families who are open to multiple services are failed due to no one service taking authority or accountability – this was identified in relation to teenagers at risk of harms outside the home, and children with disabilities or complex health needs. Research into young people affected by gang violence and criminal exploitation described families as “exasperated” by contacts with multiple services (Children’s Commissioner, 2019).

Sense of being supported or protected

Ten parents/carers described feeling a general sense of being supported by Community F:CAMHS. This was often discussed within the context of the provision of timely and responsive support for many families; for example: *“The support that we got was just what we needed at the time we needed it”* (Parent/Carer 6). Parents/carers described the facilitative nature of specialist clinicians providing input regarding their child; for example: *“it’s very hard to let go, because you just want to wrap them [children] up in cotton wool, but they have been very supportive in helping”* (Parent/Carer 15). The transformative nature of receiving support from Community F:CAMHS is also identified; for example: *“I honestly don’t think, hand on heart, that my son would still be in my care if I didn’t have that support”* (Parent/Carer 4), including its impact on the family unit *“getting that support in at the right time, changed four*

lives really” (Parent/Carer 7). Further, at times, parents/carers described a sense of feeling safeguarded as a result of input from Community F:CAMHS, particularly in relation to knowing which agencies need to be involved in the cases. For example: *“he’s [Community F:CAMHS clinician] been very good at protecting us, in terms of when people have said we need to get social services to go in”* (Parent/Carer 7).

A general sense of being supported or protected may be linked to the interpretation of the other themes, particularly in relation to parents/carers experiencing guilt, shame, and feeling overwhelmed as a result of their high risk young person (McDonald et al., 2007). The multiagency nature of support for young people that exists in all countries can quickly become uncoordinated, and therefore increases the risk of parents/carers feeling input is counterintuitive and overwhelming. Input from a specialist clinician “taking charge” of the situation, being a main point of contact, supporting and helping the parent/carer to do the best for their family is pertinent to the effective delivery of child and adolescent mental health internationally.

2) Barriers to support

Whilst many parents/carers discussed the facilitators to support in the care of their children, and positive change, there was also some suggestion that there were barriers to access support. It is important to consider these reflections because these are related, at times, to a sense of a lack of support via a lack of clear communication, joined-up services, or appropriate levels of contact.

Lack of communication, awareness, or contact

Six parents/carers described a lack of clear communication as a barrier to engaging with services to provide support to them to care for their child, and support for their child directly. This included having to coordinate communication between agencies themselves, and a lack

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of joined-up communication by agencies involved in a general sense, or a lack of awareness of Community F:CAMHS more widely. For example, when referring to communication: “[...] felt that they would [...] have clear lines of communication between the different services to [...] even just as simple as organising a meeting [...] and so I had to do that myself. But I worry for parents who aren’t like me. Or kids who don’t have parents who care so much that they wouldn’t get anywhere near this service” (Parent/Carer 2); and awareness: “[We] had a [...] family support worker – who had done a referral to F:CAMHS, because [...] I’d never heard of them before [...] I think if it was a more...a known service, and was out there, and people understood a lot more of it, people would use them” (Parent/Carer 4).

When parents/carers expressed the need for more contact, more coverage and more of the support provided by Community F:CAMHS, this was sometimes described as not meeting with the team sufficiently frequently or early; for example: “We met them once – me and [child] together while meeting with the school and that was it” (Parent/Carer 8) and “there have been definite points in [child]’s development where we could have needed the support of F:CAMHS before we were given it” (Parent/Carer 7) and “Maybe if they would have stayed for a little bit longer, they would have seen her [child] unravel and see what she’s really like, rather than just an hour’s appointment” (Parent/Carer 16).

Discussion

The aim of this research was to explore parent/carers experiences of Community F:CAMHS and to help illustrate the impact throughout England. Two superordinate themes were generated, which relate to facilitators and barriers to parents/carers being supported in the care of their child. The importance of empowering parents/carers as a central component of their child’s progress, as identified via several subthemes is demonstrated. The Community F:CAMHS consultation and liaison model is likely to be key in understanding the positive

experience of parents/carers of young people who receive input from the services; that is, the combination of forensic mental health expertise in risk assessment and risk management with the ability to provide overarching, often indirect support to the professional and parent/carer network that surrounds a young person.

Our findings illustrate that the facilitating elements of the supporting relationships may take several formats, including clear communication, “holding” a case, and acting on behalf of parents/carers, often illustrated as staying in the background and acting from a place of authority and ownership of the case. This demonstrates that Community F:CAMHS is able to contain anxieties that surround this group of young people, including those experienced by parents/carers, who are often the most exposed to the presenting risks.

One theme generated from the data was “Co-production of strategies and practical advice”. Here, parents/carers discussed the robust ability of Community F:CAMHS to teach, or upskill parents/carers so that they could be agents in their child’s care; helping the parents/carers to help the young person. Parents/carers described this as being facilitated through the co-production of strategies to help their child, or to change something about their own reactions and behavior in challenging situations. Often, parents/carers described being better able to cope with these challenging situations due to the input of Community F:CAMHS.

Further, parents/carers often described the input of Community F:CAMHS as being facilitators to understanding. The reflections here were twofold: the teams were able to provide relevant information and advice to the parents/carers to enable them to better understand the difficulties, and the teams also had a better understanding of the young people and families’ difficulties themselves. These findings highlight the importance of feeling understood as being conducive to the development of positive helping relationships, leading to effective care and positive outcomes, in support of prior research (Gyateng et al., 2014; Taylor et al., 2018). In

further support of previous research (Damen et al., 2021; Graves & Shelton, 2007; Lamers et al., 2016), the facilitative nature of parental empowerment to prompt positive outcomes is evident in the present findings.

Often input from Community F:CAMHS is described as knowledgeable, which brought a sense of “professionalism” and “expertise” to the work. Positive characteristics which enabled the development of positive relationships were also described, as well as the professionals and young people as being “well-matched”. Further, key outcomes of the Community F:CAMHS model are highlighted via all of the facilitators to support subthemes generated, which suggests that Community F:CAMHS may be providing much needed support to families to find the right “fit”, as identified in previous research as a prevailing need (Boulter & Rickwood, 2013). It also suggests that input from Community F:CAMHS enables effective joined working between multi-agency professionals, parents, and carers via the implementation of clear evidence-based pathways and improved care for high-risk young people, so they are treated in the right place, at the right time and as close to home as possible (NHS England, 2015).

The unique challenges of effectively coordinating help under complex circumstances with young people presenting with high risk and high harm behavior, including the consequent involvement with multiple agencies, seem to be mitigated by parents describing Community F:CAMHS as enabling effective joined working and clear communication between agencies is thus highly significant in nature. In keeping with this, in terms of barriers to effective support, parents/carers identified that a lack of clear communication, contact, or awareness of the teams were drivers. This is further in line with previous research, where parents/carers described lack of clear communication as a key barrier to engagement with services and finding the support that is right for the family (Boulter & Rickwood, 2013), further highlighting the need for

systemic change. Our research was conducted during the implementation phase of the newly commissioned Community F:CAMHS, meaning some services were not fully embedded at the time of data collection. All comments reflected by parents/carers which related to a lack of communication were from interviews which took place in the early phase of implementation.

Consistent barrier themes which ran throughout all implementation stages were related to a lack of contact, or a lack of knowledge about the services. This suggests that Community F:CAMHS requires further embedding in the overall provision of support for this group of young people. This is not surprising considering it takes time for key stakeholders to become aware of new services and indicates that ongoing stakeholder engagement by Community F:CAMHS is required; and perhaps it takes time for Community F:CAMHS to build sufficient trust with local stakeholders to be able to take on the position of coordinator of care. In addition, due to the nature of the work, often Community F:CAMHS input is initially between professionals, rather than with families and thus, parents/carers may feel as though they are late to hear about the services.

Strengths and Limitations

The present study adds to limited evidence-base exploring first-hand experiences of forensic services for young people, highlighting areas of positive practice which apply to different settings as well as the areas of systemic challenges occurring nationally across services, such as disjointed communication. Nonetheless, the research relied on convenience sampling, which may increase risk of non-participation bias. The findings may be led by more forthcoming participants and those with better relationships with services, while voices of quieter participants, or participants who had less positive experiences may not have been heard. As such, although efforts were made to recruit as diverse a sample as possible, the views gathered may not be representative of the wider population seen by Community F:CAMHS.

It remains a limitation that we are unable to determine the proportion of participants recruited from those parents who were invited to participate. We were also unable to explore associations between participant characteristics and findings, leaving gaps in research prevailing. A particular limitation is that participant demographics including age, mental health, ethnicity and culture could not be considered. Further research should more directly explore how individual characteristics (e.g., gender, ethnicity, socioeconomic/employment status) and young people's outcomes may impact parents or carers' experiences interacting with services such as Community F:CAMHS. This is especially important in the context of disparities in mental healthcare pathways and poorer experiences of healthcare amongst marginalized ethnic groups (e.g., Hui et al., 2021)

Implications

This study focuses on the empowerment of parents/carers of young people from England who present with a high risk of harm to self and, in particular, others in the context of mental health concerns. The deductive analysis generated themes that mapped onto the wider evaluation logic model, for example, "Clear, joined-up communication" and "Co-production of strategies and practical advice". However, the remaining subthemes generated support new theory in this area, particularly related to the unique support and empowerment of parents/carers. The Community F:CAMHS clinical model is central to understanding the effective empowerment of parents/carers: specialist, bespoke and individualized provision by expert clinicians who can coordinate across multiagency networks in an authoritative manner, via joined-up communication. Because there are internationally identified challenges, including managing the complexity of cases (e.g., Valentine, 2016 in Australia; Unger et al., 2014 in Canada; Almqvist et al., 2018 in Sweden) that we argue are mitigated by the

Community F:CAMHS approach, there is good reason to be curious about whether the Community F:CAMHS approach could be helpful globally. Consideration should be given to the provision of this clinical model in other child and adolescent mental health services, including those provided in different countries, which will include variations in the structure of multiagency support for high-risk young people.

We make this recommendation in the knowledge that innovations take around ten years to reach implementation in practice (Cooksey, 2006). Thus, there is a need to address this gap through the pragmatic stance of implementation science, which seeks to improve healthcare practices and client outcomes by breaking interventions down into easily applicable steps (Boulton et al., 2020). There are salient points from the present study which could be integrated into existing interventions and services. For example, according to parents/carers, helping to empower them in the care of their children is key to positive family outcomes. This is via a number of key tangible actions, such as consistent and good communication, “holding” (taking ownership of) cases, and acting on behalf of parents/carers in conversations across agencies. These highlighted components of Community F:CAMHS could be assembled into a framework, representing how to operationalise this intervention in practice.

Conclusion

The unique role of Community F:CAMHS in the support of parents/carers to empower them in the care of their children is apparent. There is a specific role that Community F:CAMHS undertake, which improves life chances, (pro)social engagement and enables families to stay together. Our findings suggest that Community F:CAMHS are accessible and consistent in their support in ways that parents/carers have not experienced previously. However, there is a prevailing need to further embed the Community F:CAMHS offering in

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the overall provision of support for this group of young people. According to the views of parents/carers themselves, Community F:CAMHS empowers them by being unintrusive and allowing for independent growth, “holding” cases, and being a welcome conduit of communication and source of invaluable knowledge and expertise, helping parents/carers to better understand difficulties and to cope with challenging situations.

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