Familiar challenges, promising solutions. Edinburgh Connect: a mental health consultation service for residential care staff working with looked after and accommodated children

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Abstract

Prevalence rates of mental health problems and psychiatric disorders among children and young people who are looked after and accommodated (LAAC) are higher than among the general population. The literature draws attention to key challenges for services in seeking to respond effectively to the mental health needs of LAAC children and young people that are related to awareness, service access and organisation and prioritisation of need.

Edinburgh Connect was established to provide a mental health service for looked after and accommodated children by supporting residential units and foster carers in the city through consultation. Drawing on the findings of an independent evaluation, this article focuses on the practical application of the Edinburgh Connect model of consultation and its effects, to consider the implications for practice and for service development.

Key Words: consultation, mental health, accommodated

Context

In Scotland *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* (Scottish Executive, 2004) makes bold statements about the importance of the mental health and well being of all children and young people's mental health as shared responsibility that rests with a broad range of agencies, across sectors. However, the Framework also acknowledges that some groups of children and young people are at heightened risk of poor mental health than their peers, and those who are or have been looked after and accommodated (LAAC) are among these. To ensure that these children and young people are able to access support for their emotional and mental health needs, additional support or specific action will be required. The service elements deemed necessary to achieve this include:

- The provision of training and consultation on emotional and mental health needs for residential care workers and foster carers (among others)

- Accessible and confidential support for LAAC children and young people who are feeling troubled
- Explicit arrangements within each NHS Child and Adolescent Mental Health Service (CAMHS) team for looked after and accommodated young people, including referral protocols and arrangements for care planning and review
- Liaison between specialist CAMH services and services for LAAC children and young people, including multi agency planning and commissioning to ensure the development and delivery of accessible and appropriate mental health responses for children and young people in local authority care.

Mental health of looked after and accommodated children

Research has highlighted the poor outcomes in general for children leaving residential and foster care. The experience of being in care often involves changes in placements and educational disruption (Kendrick et al., 2004) and there is evidence from a recent survey of care leavers that the majority had poor educational outcomes, and high rates of unemployment and homelessness (Dixon and Stein, 2003).

Prevalence rates of mental health problems and psychiatric disorders among children and young people who are looked after and accommodated are higher than among the general population of children and young people (Office for National Statistics, 2004; Blower et al., 2004). Surveys of self reported health and mental health among LAAC young people also indicate that many young people rate themselves as experiencing psychological problems (Chetwynd and Robb, 1999). Mental health is an area where LAAC young people themselves have identified a great need for support (Grant et al., 2003). However, barriers that young people report stand in the way of their being able to get the support required are physical, psychological and organisational (Beck, 2006).

Responding to the mental health needs of LAAC children and young people

The literature draws attention to a core set of challenges for services in seeking to respond effectively to the mental health needs of LAAC children and young people:
- Awareness raising and understanding of mental health
- Access to appropriate care, treatment and support
- Service and organisational issues
- Strategic prioritisation of LAAC mental health

Awareness and understanding of mental health

In general residential and foster care staff have not traditionally been equipped with the skills, knowledge and confidence required to address mental health (Talbot 2004; Health Scotland, 2006). Foster carers can be particularly isolated and unsupported and one study suggested that they lacked information about the mental health needs of the young person to be able to support him or her effectively (Callaghan et al., 2003).
The areas of skills and knowledge required have been detailed as follows: the recognition of mental-health problems, such as depression, anxiety, eating disorders and self-harm; knowl-

edge about the referral process and ways of accessing the service; understanding of aspects of treatment; and child mental health in the context of the social care system (Arcelus et al., 1999).

At a more fundamental level, there are frequent references in the practice literature to the need to establish a common language and terminology in relation to mental health, to create the preconditions for more effective integrated working across professional and sectoral boundaries (Arcelus et al., 1999; Little, 2003). Others contend that many of the difficulties surrounding inter-professional work in the field of LAAC mental health are associated with differing conceptions of and terminology to describe behaviour, and disagreements concerning the value of psychiatric diagnosis (Stanley et al., 2005). Scott (2004) takes this analysis a stage further in her review of research on the mental health of LAAC young people, to pose challenges about the overarching goals of service interventions and the difference in approach required to pursue mental health promotion and prevention, rather than only to respond to immediate needs for assessment, care and treatment.

Access to appropriate care, support and treatment

The problems in accessing mental health services for this population of children and young people have been well documented and include narrow referral criteria, non-detection of mental health problems, referrers' reluctance to pathologise children's behaviour, children's mobility and engagement (Callaghan et al., 2003). The quality of relationships between professionals can also be a constraint (Health Scotland, 2006). Young people can face a lack of choice and may have to pass through too many other services first before they get access to what they really need. The services are often perceived as being overly formal, and the surroundings and staff not sufficiently welcoming for children and young people (Bryce, 2003; Watson et al., 2003). These barriers have led some experienced clinicians to call into question the rationale for service access being contingent on having a psychiatric disorder (Bryce, 2003).

Often young people may not be aware that the services exist, may have difficulty getting information about them, or the information available may not be appropriate to children and young people (Watson et al., 2003; Talbot, 2004). For professionals, securing accessing services for these children can be complicated and referral pathways and criteria confusing (BPS, 2004). Bringing services to young people may be more effective (Big Step, 2001). Grant et al. (2003) make the case for easily accessed mental health support and advice at all levels, ranging from support, training and consultation for unit staff through to the specialist tertiary level.

One research study found that the main gap in current service provision lay in delivering effective interventions to children whose mental health problems had already been well identified, but where these problems proved persistent, disabling and hard to manage (Blower et al., 2004). Other commentators have stressed the need for more effective prioritisation of cases and partnership working between services (Arcelus et al., 1999) and for prompt, relevant and expert multi-agency support (BPS, 2004).

Service and organisational issues

Much attention has been given in the literature to describing and explaining the relationship between CAMH service system and residential care system. It has been recognized that this relationship has often been a tense one (Callaghan et al., 2003). Competing targets and serious and persisting resource pressures on both sets of services, ill-defined or ill-understood boundaries and thresholds, lack of effective channels for communication, the absence of a shared

language and of mutual understanding of roles and priorities have stood in the way of effective collaborative working.

Strategic prioritisation

Experience suggests that unless the interests of disadvantaged children and young people such as those who are LAAC are protected and services are adapted to take account of their high levels of mobility and lack of advocacy, other more stable populations will tend to take precedence in children's services planning and prioritisation (Arecelus et al., 1999).

Services for looked after and accommodated children in Edinburgh

There are 15 residential units for looked after and accommodated children in Edinburgh:

- Seven Young People's Centres which function as open units
- 2 Secure Units
- 3 Close Support Units, two of which are in the grounds of the Secure Units
- 1 Family Support Centre for children of primary school age, which initially offered respite and now provides short term care and outreach
- 1 unit that undertakes long term work with primary school aged children. This is a joint unit, involving the Social Work Department and a voluntary sector provider
- 1 residential school for boys with emotional or behavioural problems. The school also provides day places.

At the time of the study, these units were part of the City of Edinburgh Council's Children and Families Social Work Services. In 2003-04 there were 1265 admissions to residential accommodation in the City of Edinburgh and 2175 discharges, with around 140 residents at any one time, of whom the majority (65%) were boys. The average age on admission was 13 years and 10months (close to the Scottish average of 13 years and 9months) and the average length of stay was 10 months (slightly below the Scottish average of 13 months). There were approximately four times as many children in foster care than in residential care.

In the Lothian region, in which Edinburgh is located, the Child and Family Mental Health service deals with children up to the age of 14. Services provided by the Young People's Unit cover those aged 14-18, with the exception of the inpatient unit which covers 10-18 year olds (Scottish Executive, 2005).

The Edinburgh Connect service

Drawing on the findings of an independent evaluation, this article focuses on the practical application of the Edinburgh Connect model of consultation and its effects, to consider the implications for practice and for service development.

Edinburgh Connect is a mental health service for looked after and accommodated children which aims to promote and enhance the mental health of this group. The service seeks to achieve this by:

- Supporting residential care workers and foster carers to meet the mental health needs of looked after and accommodated children and young people through consultation and co-working; by identifying tools for assessment and processes and frameworks to support the delivery of therapeutic interventions; and by working with staff and carers to identify and address training needs related to mental health
- Undertaking direct work with children and young people who are looked after and accommodated
- Contributing to strategic and operational development of services to enhance LAAC mental health.

The service is jointly funded by both health and social work services and is overseen by a multiagency steering group.

From the outset, Edinburgh Connect set out to address documented systemic and organisational difficulties in working with LAAC mental health, by designing and implementing an operational model that would achieve the following outcomes:

- Promote understanding of mental health and well being among those working with LAAC children and young people
- Foster a sense of ownership and responsibility among carers for the mental health and well being of the young people in their care, to promote an understanding of needs and to facilitate the development of effective strategies to respond
- Build capacity by enhancing and reinforcing skills, knowledge and confidence and by furnishing access to relevant tools and resources (e.g. for assessment).

The theoretical framework from which the EC model derived drew on several different bodies of knowledge:

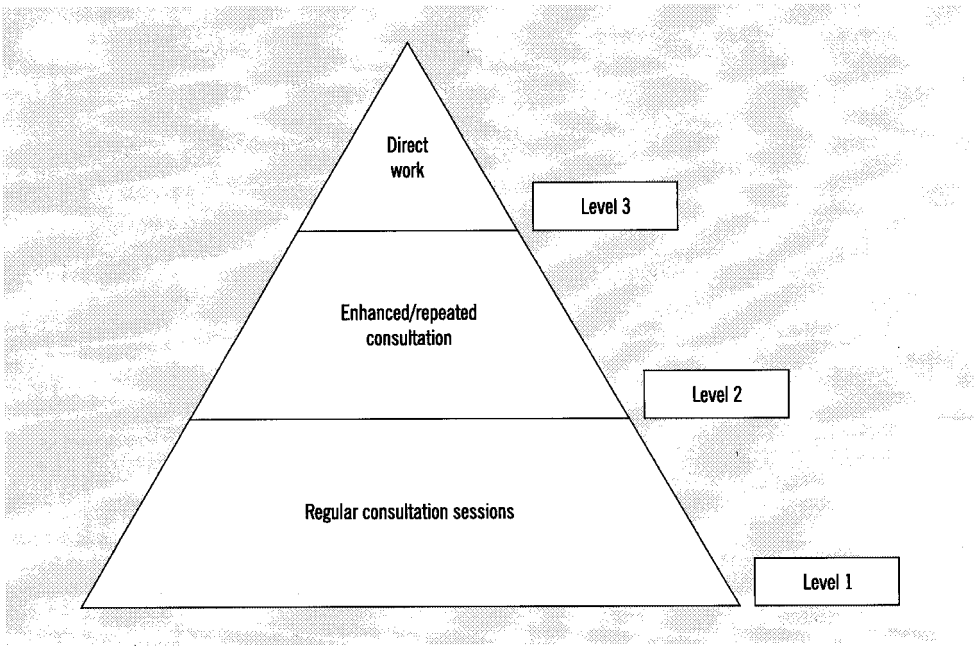

Figure 1
The Edinburgh Connect Service Model

- The dynamics of groups and organizations as these relate to residential care and foster care settings
- Principles of systemic practice which serve as a guide for interventions at differing levels within a system
- A psychodynamic understanding of the factors that shape the mental health and well being of children and young people in general and of how being looked after and accommodated can affect mental health and well being.

Edinburgh Connect illustrated their working model according to Figure 1.

The main building block was the regular consultation work undertaken with residential care staff (Level 1). A designated pair of Edinburgh Connect team members worked with each unit. Consultation meetings were regularly scheduled with each unit, initially on a three weekly cycle, latterly every four weeks. Level 2 consultations involved more in-depth, follow-on consultations with key workers.

Consultations focused on individual young people, wider practice issues relating to group dynamics or organisational factors that impact on the mental health and well being of residents. Edinburgh Connect was also available to staff outside the consultation meetings, to offer telephone advice. The relationships established with the units by Edinburgh Connect developed into other areas, for example offering mental health awareness training for unit staff, where the latter identify a need for this.

At Level 3, Edinburgh Connect worked individually with young people in the residential units. This remained a relatively small element of the team's work.

Evaluation design and methods

Edinburgh Connect commissioned the Scottish Development Centre for Mental Health to undertake an independent evaluation of the service. The evaluation was designed in close discussion with the Edinburgh Connect team and Steering Group to ensure flexibility and responsiveness over the two and half year period of the evaluation to feed back into and inform the development of the service.

The evaluation aimed to:

1. Track progress in relation to the identified strategic and operational objectives set out above
2. Inform the continuing development of the Edinburgh Connect service by building into the evaluation process regular opportunities for feedback and reflection
3. Examine, from the perspectives of a range of stakeholders, the factors that facilitated and inhibited the effectiveness of the team and the achievement of its objectives (including factors within the team; structures; procedures and working practices; attitudes, culture and behaviour)
4. Identify key learning points and recommendations for the longer term development of local service responses to meet the mental health needs of looked after and accommodated children and young people in Edinburgh.

The evaluation was concerned primarily with process rather than outcome, to examine the nature of the service model and understand how it was implemented in practice. This was considered important in order to document the development of a service model that was viewed as ground-breaking and that was seeking to address known systemic and organisational

difficulties in responding to the mental health needs of this population. Consequently, data collection methods were largely qualitative, supplemented by routine monitoring data.

Stage 1 of the evaluation (August 2003 to March 2004) was a foundation phase which set out to explore the aims, objectives and role of the team from the perspectives of key stakeholders; identify the activities and interventions that stakeholders perceived to be required for the team to achieve its objectives; and gather baseline contextual information on organisational structures and networks of support within which the team is located.

Stage 2 of the evaluation (April 2004 to March 2005) was focused on the following objectives:

- Examining the service model of capacity building, in particular:
  - consultation work and service agreements with residential units (RUs)
  - consultation with foster carers
- Exploring the role of Edinburgh Connect in the wider service system and its relationships with other mental health and LAAC services
- Consulting LAAC young people about mental health issues and about the work of Edinburgh Connect
- Tracking the development of the service and identifying emerging issues for service and practice development

Stage 3 (April to Nov 2005) consolidated and completed data collection and reviewed national and local strategic developments relevant to LAAC mental health to consider the implications for the development of the service and of mental health responses for LAAC young people in Edinburgh.

Findings

Embedding the consultation model in the work of the Residential Units

Edinburgh Connect implemented a number of strategies to build engagement with the 15 residential units: holding regular consultation sessions in each unit, introducing a formal service agreement with all units and developing a system of link workers in units. The rationale behind this was to regularise and embed the consultation model as a core part of units' work.

Regularising consultation

Edinburgh Connect focused on capacity building in its work with residential units and foster carers, using the tiered model to provide regular consultation, follow up advice, proactive support, training for residential staff and direct work with young people. The cornerstone of this work was the consultation sessions undertaken regularly with all units. The formalisation of the consultations as part of the 'routine' work in units was commonly regarded as a distinctive and positive feature. Previous use of consultation to provide support to residential care had tended to be reactive following a crisis or serious incident and, however valuable in the short term, had proved to have limitations in achieving lasting impact on practice. Unit managers and staff viewed the regularity of EC contact as instrumental in creating and sustaining an effective working relationship with units and in promoting the integration of mental health awareness into day to day practice.

The EC team and several managers considered that the regularity of contact with units went some way to ensure equity in the availability of mental health expertise to children and young people in different units. However there proved to be considerable variability in practice in the extent to which individual units made use of EC and this was a cause for concern among some stakeholders.

Both the EC team and the Residential Unit Managers described how it had taken time for the working relationship between the team and the individual units to develop, in ways which enabled consultation to be used effectively. After initial uncertainty, during which units tended to use the consultations to discuss a larger number of cases in less depth, and through a process of testing out the best use of consultation, there were clear indications that Edinburgh Connect had become a highly valued resource for the units. Unit managers indicated that trust was an important component of the relationship with EC, and regular contact between EC and units has been key in building trust between units and the EC team.

Service agreements with units

In its second year of operation EC introduced the agreements and began to establish a link worker system (see below) in each unit as further steps to build capacity and to clarify responsibilities. Unit Managers saw the introduction of this agreement as a means to help raise and maintain awareness of what the EC service could offer both among newly recruited residential care staff and among external agencies who came into contact with the Units. In addition, the agreement was helpful in clarifying expectations and responsibilities of both partners (the EC team and Unit staff). Some also saw the agreements as a means of ensuring more uniform access to the services of EC. The EC team viewed the agreements as necessary, to set out the terms of engagement, but not sufficient; considerable commitment and investment continued to be required to build a mutually respectful working relationship with a unit.

Link worker system

Link workers saw their role as having a number of purposes:

- To feed back information from EC to units, e.g. information about new materials in the EC resource bank or about future EC training events. For this part of their role, link workers regarded the support of unit managers as crucial, to enable ideas to be integrated in practice
- Preparation for EC consultations, by making sure information from units is sent through to EC in advance
- To build their own knowledge and understanding of mental health.

Regular two monthly meetings were the main vehicle for link workers to exchange information with EC and get support with role development through sharing experiences.
Progress in establishing a network of active link workers in all units proved to be variable, mirroring the general pattern of engagement between units and EC. Some units were rarely if ever represented at the regular link worker network meetings with EC.

Link workers had concerns that mental health could be seen as their role exclusively or that, at the other extreme, mental health became everyone's business, to the extent where their role was only administrative, arranging meetings, or dealing with correspondence. The EC team were aware that the role of link worker could be difficult if people felt isolated and unsure. Despite these reservations, there was a shared view that the role was still relatively new and there was potential to develop it further within units.

Patterns of activity and engagement

Activity

The tables below present details of the volume and level of work undertaken by Edinburgh Connect in supporting 15 units and indicate trends over time.

Table 1
Number of consultations April 2003-Sept 2005

	No. of consultations 2003-2004	No. of consultations 2004-2005	No. of consultations 2005 (6m only)
Level 1	167	243	121
Level 2	140	127	58
Level 3	138	187	131

Table 2
Number of young people discussed

	No. of YP discussed 2003-2004	No. of YP discussed 2004-2005	No. of YP discussed 2005 (6m only)
Level 1	227	112	67
Level 2	46	58	34
Level 3	18	28	26

The number of Level 1 consultation sessions undertaken by Edinburgh Connect with units increased considerably from Year 1 to Year 2 while the number of children and young people decreased by half. This suggests that Level 1 consultations had become more in-depth. This pattern continued into Year 3. The number of Level 2 (enhanced) consultations decreased slightly over time, but more cases were discussed.

In relation to direct work with young people, the number of sessions increased from Year 1 to Year 2 by a third and the number of young people seen also rose from 18 to 28. Figures for the first half of Year 3 show a continuing rise in the number of young people engaged in direct work (26 in the space of six months). Level 3 work tended to be relatively intensive and involved on average five to six consultations per young person. This compares with an average of two per young people discussed at Level 1 and an average of between two and three sessions at Level 2. Level 3 work also involved an element of family work: 14 of the 187 Level 3 consultations in Year 2 were family sessions as were 13 of the 131 sessions undertaken in the first half of Year 3, involving three families.

Taken together these figures suggest that over time Edinburgh Connect developed a more intensive and more focused service, working in greater depth with the unit staff, with young people themselves and their families.

Figure 2 below shows the pathways followed by those young people involved with EC either through consultation and/or direct contact.

Figure 2
Care pathways: April 2004-March 2005

Young people discussed in Level 1 consultations	112
Young people discussed at Level 2 in enhanced/repeated consultations	58
Main outcomes from Level 2 consultation:	
• Further consultation agreed	37
• Further consultation agreed on request	13
• Level III work	16
• Referral to CAMHS recommended	8
• Involvement of CAMH in L2 consultation	1
• Continued working with CAMHS	1
• Referral to other services	1
Young people identified for direct work	28
• Did not engage	1
• Assessment only	7
• On-going work undertaken	20
• Seen by the EC Consultant Psychiatrist	5

Engagement with residential units

The quality and depth of work that Edinburgh Connect was able to undertake with each unit varied considerably: while some units were more receptive to using Edinburgh Connect as a resource, a small number remained less engaged and made consistently less use of consultation on a regular basis. In 2004-05, the number of consultations sessions per unit varied from 8-16 depending on how frequently scheduled consultations were cancelled and not rearranged. As a corollary, the number of young people discussed in consultation ranged from 5 to 12 per unit over this period.

The issue of variability and equity was a key recurring theme that became increasingly pronounced over time. There was little to suggest that the mental health needs of those young people in units which made less use of Edinburgh Connect were any different to the mental health needs of their peers in other units. The team was aware that a small number of units were much less open to working with them. Approaches for help from these units tended to come to the team at a stage when a situation had become serious and a young person was experiencing significant mental health problems.

Ownership was seen as one part of the issue. In addition, the lower levels of engagement achieved with some units were thought to be attributable to the management style and culture in units. Residential care officers, service managers and Edinburgh Connect team members shared this view. The limited involvement of the team with these units was seen as part of a wider pattern that was said to be replicated in the units' relationships with other external services.

Positive engagement was associated with units that encouraged openness and a learning culture amongst staff. Edinburgh Connect was recognised as being 'challenging of your practice' from time to time, which required that units had a level of self confidence to be able to support this. Less positive engagement was attributed to closed practice, or differences in the

value base between Edinburgh Connect and unit staff. One unit manager considered that some of their peers remained less receptive to mental health issues. In all these cases the role of unit manager was seen as key in influencing the level of engagement.

For the team this variability in levels of engagement posed challenges in ensuring that it retained at least a minimum contact with all units and the team was acutely aware that the young people in these units had access to less support with mental health than their peers in other units. Further, EC considered that it was able to offer an external perspective to add value and promote good practice within units and that without this, young people could be vulnerable.

The consultation model in practice

Core principles

The model of consultation developed by Edinburgh Connect rested on a set of core principles, which emerged from the team's theoretical orientation and from their practice experience of working in settings that operated as closed institutions. Firstly, consultation entailed supporting staff to consider the formulation of presenting and underlying issues and to identify solutions, and was not about accessing external 'expertise'. The model relied on a collaborative approach: Edinburgh Connect brought a 'fresh perspective' informed by knowledge and expertise in mental health strategies and interventions, as well as possibly prior knowledge of the young person or their family; the units brought expertise in working with the young person day-to-day. Secondly, throughout consultation, ownership remained with the consultee that is the care staff. Thirdly, the purpose of consultation was to enhance capacity and this required building relationships of trust and respect. Offering regularised predictable, consistent and reliable consultation was seen as vital to allow working relationships to grow and learning to take place. Fourthly, engaging effectively with complex systems like residential care required working at several different levels with attention to the interaction between different levels of input.

Selection of cases for consultation

Four residential units took part in a case study exercise and, over a three month period, detailing 21 cases brought to consultation. From the records made by Edinburgh Connect and by unit key workers, there were several sets of issues that led to a case being brought to consultation. These reflected both the specific problems posed and difficulties experienced by children and young people, and the needs of staff in managing these problems and their effects:

- A deterioration, or (adverse) change in the young person's situation or behaviour, including e.g. physical health, self-harming
- The complexity of behavioural or emotional issues presented by the young person, including past sexual abuse/severe deprivation
- Risks to which a young person may be exposed, including child protection
- Relationship issues: between the young person and their family/friends; between the young person and staff; and between staff and the family
- Intervention issues including consideration of direct work/individual therapies, managing behaviours/impact of the young person's past experience and managing transitions

- Systemic issues, for example, involving social work departments where there are child protection issues.
- Staff sense of "stuck-ness", "frustration" or "struggling" and a wish to identify appropriate strategies for responding to the young person.

Outcomes from consultation

Outcomes reported from the consultations fell into three sets:

- Practical outcomes, for example, a decision made for a health worker to accompany a young person to medical appointments; making available an additional out-reach session for a young person; Edinburgh Connect undertaking direct work; contact with parent, following advice from Edinburgh Connect; development of guidelines for dealing with confrontation; introduction of strategies to help the young person and empower staff both in dealing with the young person, the families of young people and other professionals.
- Outcomes relating to improvements in the quality of responses to the young person, for example:
  - Better understanding of the young person – the impact of their past experiences and current family dynamics on their behaviour/presentation – being "clear in your own mind where young person is coming from"
  - Being able to work with a young person more efficiently
  - Greater clarity of approach, being more proactive and giving more attention to planning for the future
  - Improved communication between all the different parties involved – "opening up the floodgates"
  - Better understanding of the pros and cons of different options
  - Being able to generalise what is learned from dealing with particular situations.
- Outcomes that related to the capability of unit staff to support the young person, for example:
  - Having a better understanding of how the unit can support a young person
  - Feeling "reassured", supported and less anxious
  - Having an opportunity to talk about the feelings particular young people may generate among staff, in view of potential issues generated and the effects of transference.

Discussion and conclusion

The literature on mental health responses for LAAC children and mental health draws attention to difficulties and challenges in ensuring that the mental health needs of LAAC young people are effectively addressed. The Edinburgh Connect service model was designed explicitly to address these systemic issues, informed by an analysis of the general and particular local barriers that stood in the way of the LAAC population receiving an effective response to their mental health needs within residential care, from CAMH services and through these two service systems working together.

The evaluation demonstrated the value of retaining a strong focus on capacity building as a core function of Edinburgh Connect in its work with residential units and the positive impact of this in promoting better understanding of mental health and improving responses available to young people who experienced mental health problems.

Although considerable progress had been made by most units and Edinburgh Connect towards collaborative working, units' levels of engagement with the service were not consistent and a

small number continued to be more distant and make less direct use of the resources available. There was general agreement that this was a question of unit culture and management and leadership style and was not an indication that the mental health needs of young people in those units were less than or different to those of young people in other units.

- A clear theoretical model of consultation, premised on multiple levels of intervention within the care system to facilitate change at individual, unit and organisational level. The design of the service model was shaped by a systemic analysis of the nature of the problems that stood in the way of services responding effectively and working collaboratively to address LAAC mental health.
- Recognition of the importance of engagement and relationship building, as the foundation for strengthening capacity. This led to the regularisation of contact between EC and the units as set out in a service agreement and meant that all units had at least some degree of contact with EC. It was evident that relationships between the team and the units evolved and matured over time, through a process of dialogue and mutual respect for expertise. Central to the relationships between the EC team and units and foster care service was an expectation that ownership and responsibility should rest with those providing care and that the purpose of the consultation was to strengthen care providers in their roles, to achieve better mental health outcomes for children and young people in their service.
- Ability to offer a broad range of expertise, as a multi disciplinary service that latterly included a sessional consultant psychiatrist, but was not consultant led. The team brought expertise in mental health coupled with an understanding of group and organisational dynamics, to work with the relationships and structures around the young person. Working in pairs with each of the units allowed the latter to access a breadth of experience and expertise, whilst team members benefited from mutual support and opportunities to share ideas and knowledge.

Figure 3
Key features of the Edinburgh Connect consultation model

Over time, Edinburgh Connect had eased working relationships between residential care services and CAMH services. Young people in residential care had clearer pathways and readier access to specialist mental health assessment and interventions through Edinburgh Connect and as a result of the team's role in facilitating appropriate referral to CAMH services. The team had been able to secure dedicated psychiatric input for the LAAC population. In addition, CAMH services acknowledged and respected Edinburgh Connect referrals and assessments.

The overall impact on residential units is a considerable achievement in view of what is known firstly, about the difficulties of intervening in and influencing closed systems such as residential care and secondly, about the scale and level of mental health need among LAAC young people. Further, the establishment of the Edinburgh Connect service had taken place against a background of considerable structural change both in the local authority child and family services (with the reshaping of departmental structures and the review of residential care) and in the CAMH services (with the integration into a single management structure of the Child and Family Mental Health Service and the Young People's Unit). Despite the challenges associated with change of this order, these developments presented new opportunities for Edinburgh Connect to become more firmly embedded in the new structures.

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