

<b>Contact details for respondent</b>	
Name	
Job title	Consultant Child and Adolescent Psychiatrist
Do you represent an organisation?  (if so, name of organisation and type: e.g. voluntary, public body, private company).	No
Postal address	Rose Hill House, 1, Rose Lane, Mossley Hill, Liverpool L18 8ES
Telephone number	

	<b>Which area of the review are you responding to? (please mark X)</b>
Prevention strand	
Review of disabled children	
Strategy for youth services	
Review of high cost, high harm families	X

My comments are brief:

- 1) While high cost/high harm families need individual attention, they invariably 'grow' in a community context and much of the work does not make any difference unless this is addressed.
- 2) The term 'high cost/high harm' is blaming and judgemental. I have concern that some of the language in the 'respect' agenda and some other initiatives such as this may also cause harm despite their intent. While it is important to be straight with families if things are harmful, this is important with governments too.
- 3) Re. preventive work: Families need family services. In contrast for instance to countries such as Canada with their family resource programmes there is a lack of universal family services in this country. Further details re universal family services can be obtained from the following publication: Synergy: Integrated Approaches in Family Support; by FRP Canada. Web site: [http://www.frp.ca/g\\_PublicationsList.asp](http://www.frp.ca/g_PublicationsList.asp).

- 4) In order to intervene with high cost - high problem - high trauma families, one needs to provide services at both the preventive level and the problem level. There are some good services in this country, namely the Marlborough family service, and the Newcastle NCH service. However, the most comprehensive approach with evidence to support its effectiveness is described in: Swenson, Henggeler, Taylor & Addison (2005): Multisystemic therapy and neighbourhood partnerships – reducing adolescent violence and substance abuse, New York, Guilford.
- 5) Services not to provide: there is a plethora of services out there, many very good, and many in the voluntary sector. While undoubtedly very good for much of the mental health needs of the population they will not always be effective and helpful with complex situations because of the difficulty of long-term commitment and planning, the inherent difficulty of integrating what such services have to offer, and the risk of reverting back to old patterns because of lack of continuity of effective support. In such instances service provision of the ‘wrong’ kind can ultimately cause more harm than good. This applies to both intervention and prevention services.
- 6) All evidence based approaches that make a difference are capable of achieving a degree of complexity of intervention and integration. Any approach needs to be able to address also parental mental health needs, especially for parents with complexity such as personality disorder (see Action 16, Social Exclusion Report). This needs to be fed into the current development of Nice Guidelines for personality disorders as a specific need that has to be addressed. Every single symptom of any personality disorder listed in DSM IV has an adverse impact on parenting. High cost – high problem – high trauma families have a high proportion of parents that would be diagnosable as suffering from a personality disorder.
- 7) We could probably offer suitable pilot sites in Liverpool for a trial of a replication of an adapted version of the MST approach described in the above book (point 4). There are several circumscribed very high-deprivation communities within my service’s area (South Liverpool CAMHS) alone that would be suitable for this.