‘Whose baby is it anyway?’ Developing a joined-up service involving child and adult teams working in a mental health trust

Clive Britten and Amynta Cardwell describe how clinicians from a London-based child and adolescent mental health service (CAMHS), in partnership with the National Society for the Prevention of Cruelty to Children (NSPCC), developed a joined-up service with colleagues in the local adult mental health teams at St Charles Hospital. The aim was to raise awareness of the potential risk factors posed to children being cared for by an adult with a mental health problem and to provide a designated clinical service for this particular client group. In discussing how the service developed, the authors highlight key learning points and identify the sources they have drawn on. These include direct clinical work, the findings of other colleagues working in the mental health field and methodological approaches designed by practitioners specialising in cross-boundary working.

Introduction

This article describes how clinicians from a child and adolescent mental health service (CAMHS), based at Parkside Clinic in North Kensington, London, in partnership with the National Society for the Prevention of Cruelty to Children (NSPCC), developed a joined-up service with colleagues in the local adult mental health teams attached to St Charles Hospital. The remit of the service, which came to be known as the parental mental health service (PMHS), was to raise awareness of the potential risk factors posed to children being cared for by an adult whose own mental health issues may well be exacerbated by the demands of being a parent, and to provide a designated clinical service for this particular client group. Through a description of how the service developed, we will draw attention to key learning points and identify the sources we have drawn on. These include direct clinical work, the findings of other colleagues working in the mental health field and methodological approaches designed by practitioners specialising in the area of cross-boundary working. Several colleagues within the Central and North West London Mental Health Trust have been involved in the development of this service and we are mindful that this account is written from the perspective of just two members of the team.

The context

In research carried out by the NSPCC in 1997, a small sample of parents with mental health problems in Brent expressed the belief that adult patients were convinced that if they became unwell they faced the threat of their children being taken into care (NSPCC Practice Development Unit, 1997). Parents reported that they found little co-ordination in the care planned for their own mental health needs and the needs of their children, typified by duplicated meetings and assessment interviews.

This research resonated with our clinical findings at Parkside Clinic in cases where a parent had a mental health issue. We were particularly struck by the following questions about both individual children and service responses more generally:

- What are the factors, resources and abilities that enable some parents with mental health difficulties with whom we have worked to make good use of local services, to adequately meet their children’s needs and to maintain networks of support which they can draw on if they become unwell?

- What might have been different for an adolescent with problems related to fat-phobic attitudes, if the services offered to the parent, also suffering from an eating disorder, had been co-ordinated within a multi-agency context including health visitors, paediatricians, general practitioners (GPs) and adult services? Who was
How might the work we did with the education service involving a child’s school phobia have been more successful if we had understood more about both parents’ mental health difficulties and had stopped offering interventions that would never be manageable for the family?

Who is responsible for talking to a child when the parent is admitted for in-patient treatment and how might this explanation, the process and the content, impact on their sleeping difficulties at their foster carers?

How is it that the referrals we were receiving, involving allegations of child abuse, did not routinely include relevant information about a parent’s psychiatric history?

Inevitably, the quality of inter-action between carers and children is affected by mental health issues. Extreme examples of the inter-reaction were evident in Adrian Falkov’s 1996 analysis of 100 fatal child abuse case reviews (Falkov, 1998). He concluded that 25 per cent of the adults who killed a child in their care were experiencing some form of psychiatric morbidity. Psychosis featured in ten of the cases, depression and ‘personality disorder’ in five cases and drug-dependency and Munchausen syndrome by proxy in two. It has to be noted that in some of the reviews the information about the mental health of the child’s carer was not available or was insufficient. In addition, Falkov (1998) cited statistics showing that women aged 20–40, traditionally most responsible for child care, made up 20 per cent of all in-patient admissions.

The extensive work carried out by Reder et al (2000) in this field culminated in a recent publication, with contributions from both the child and adult perspective. The book provides research data and clinical findings that support recommendations for a change in the way adult and child mental health colleagues work together in order to assess and meet the needs of children and families where a carer has a mental health diagnosis which is adversely affecting their capacity to parent.

A central point made by Duncan and Reder (2000) is that clinicians working in both child and adult services need to assess and identify the sorts of behaviours an adult might be presenting with, and consider the implications from the child’s perspective. What might they have been subjected to? What might they have seen? More attention should be given to the specific sorts of behaviours a child is actually subjected to by their carer, rather than assuming that by identifying the diagnosis of the adult the risks to the child are clear. The authors also suggest looking at the developmental stage of the child and the prognosis and treatment for the adult again from the child’s point of view.

For example, what might it be like when a child witnesses their parent undergoing a psychotic episode? Is the child included in the delusional system? Should the parent be treated at home by the crisis resolution team set up to treat adults at home and reduce the heavy demand on hospital beds, or would in-patient care be more appropriate?

Hodes (2000) has a special interest in the relationship between parent and child eating problems and recommends that, where appropriate, parents with eating disorders have greater access to services providing them support with certain parenting tasks to ensure that their children do not develop their own unhealthy eating behaviours.

Bearing out our own findings that long-standing barriers – organisational, theoretical and philosophical – divide adult and child mental health services at a cost to families, Reder et al (2000) propose that resources need to be made available to improve interface working between adult and child mental health services in order to meet the needs of these families.

Other factors informing the context were the NHS policy documents pointing to the need for service providers to address the issue of working across traditional organisational boundaries and

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Against this background of support for the strategic value of joined-up service provision within the NHS modernisation agenda, and the findings of clinicians in adult and child services, there was a recognition by managers within our local Trust that the parental mental health service was a pragmatic and timely response.

However, they also recognised that if the service was to succeed in addressing the complex needs of this particular client group, it would require a change in the way adult and child services had traditionally worked together.

**Developing the parental mental health service**

Given the context outlined above, the CAMHS service director negotiated a joint partnership agreement with the NSPCC which involved a commitment to designate resources to fund a project that has come to be known as the parental mental health service (PMHS).

While working closely with other local agencies providing services for children, such as social services and education, attention was to be mainly focused on the local adult psychiatric service, based at St Charles Hospital in North Kensington. The adult service consists of three community mental health teams, a crisis resolution team, three in-patient wards, a 24-hour duty service, a day hospital and an out-patient clinic.

The PMHS team is made up of clinicians from a variety of different disciplines including child and adult psychotherapy, family therapy, clinical psychology, child psychiatry and social work. They are employed by CAMHS and the NSPCC, and are able to contribute varying amounts of time to the development of the service.

The team agreed that their task was to find more effective ways to link up with the adult mental health teams so that the conditions were in place to provide adult mental health service users known to have children with the following:

- direct clinical work for parents and their children – with clinicians drawing from a range of approaches depending on the context of the work, including family therapy using the systemic model, a solution-focused approach, cognitive and behavioural therapy, the medical model and psychodyamic work with the child;
- improved links with adult colleagues so that adult patients' care was co-ordinated with services being offered or needed for their children.

An indicator of success would be reflected in an increase in direct referrals to Parkside Clinic from St Charles Hospital of children whose parents are in receipt of or who are known to the adult service.

**Initial approaches and interventions**

In order to take the PMHS forward from a project phase and accomplish the agreed tasks, various initiatives were set up:

- The PMHS team visited the three different adult mental health teams to market the service. They proposed that referrals come directly to the service rather than via the GP.
- Joint training was provided for adult clinicians, looking at child protection in the context of parental mental illness, held at Parkside Clinic.
- A multi-agency forum offered practitioners from adult and child services an opportunity to discuss cases where there were concerns about parental mental health issues.
- A freelance consultant was employed to design a ‘link initiative’ whereby adult clinicians, appointed as link workers, would liaise with children’s services about patients who had children.

However, despite these interventions, over time, no significant increase occurred in the referral rates of children from the adult service and no obvious change was apparent in the way the two teams liaised about cases.
We concluded that engaging the three adult community mental health teams would require a different approach, so resources were directed towards funding a family therapy post, with a remit to work flexibly at the interface in order to further the aims of the PMHS.

In order to arrive at a mutually agreed way of working between adult and children's services, the family therapist drew on ideas and methodologies developed by Inter-Logics, a group of researchers who work with organisations at a strategic level to develop practical methods for inter-organisational working (Anderson-Wallace et al., 2001). The application of their ideas in another NHS context is described in a paper jointly written with the commissioning Chief Executive, Antek Lejk (Anderson-Wallace et al., 2000).

This approach is informed by theoretical ideas from a number of fields including social constructionism, pragmatics, linguistics and dialogical theory. Here action is seen as jointly produced through communication and in context, with attention given to what can be achieved together in situations where purposes and expertise are different. It involves extensive enquiry, either face to face, online or through questionnaires, with a focus on the diverse priorities and varying contributions of all key stakeholders and finding ways to co-ordinate activities accordingly.

Application of these ideas led to further discussions between the adult team and the family therapist to address how the CAMHS might alter their approach in order to give the aims of the PMHS a better chance of success. The family therapist approached clinicians and managers within the adult community mental health teams and other departments in the hospital. Whole team interviews and questionnaires were used to learn more about the adult context and hear directly from clinicians how they might best work together. These methods led to an acknowledgement that previous efforts to work collaboratively had not always been successful. Naming this failure provided a basis for discussing how the new joint service might create a useful opportunity to do things differently, while also building on the experiences that had happened in the past where there was evidence of effective joined-up working (Anderson-Wallace et al., 2001).

Once it was clear that the PMHS could be of use to patients receiving the adult service, that designated resources were on offer and that CAMHS were going to design the parental service in consultation with adult colleagues, it became possible to agree what child and adult staff could actually do together to take the service forward, avoiding a familiar trap of focusing on who must change (Anderson-Wallace et al., 2001).

Thus the service developed on the basis of collaboration and attention to the different views and purposes across the child and adult services.

From project to service

In consultation with the adult services, the family therapist agreed to offer a variety of clinical interventions for adult patients that would be made available through both informal and formal pathways. It was agreed that regular attendance by a representative of the PMHS at each weekly adult community mental health intake team meeting would ensure that appropriate cases could be picked up at the point of referral.

New referrals coming into the adult team would be seen by a member of the adult team together with the family therapist for a joint assessment. Appropriate cases would then be referred into CAMHS, and case updates would be fed back to the adult team at the meeting following the assessment. In addition, adult clinicians and the family therapist would provide consultation to each other drawing on their respective expertise about the adult and child mental health issues. Conversely, cases known to children’s services, where there are concerns about an adult mental health issue, are referred in the opposite direction.

The family therapist role in the joint assessment was to open up the following areas as appropriate:

- the sorts of behaviours that a child living with a referred adult might be subjected to;
whether parents or professionals had any concerns about a child;
• the identification of coping strategies and resources of the adult patient;
• networks of family, cultural, religious and professional support;

The therapist offered ongoing work at Parkside Clinic and/or referred elsewhere where appropriate when child protection issues were present and liaison took place with social services.

It is set out in the PMHS referral policy that following the assessment clinical responsibility for the adult patient resides with the adult team while clinical responsibility for the child/ren lies with the children’s services. This means that the liaison tasks are shared out accordingly. If ongoing treatment goes ahead within CAMHS, it is co-ordinated according to the needs of the families and, as described above, can involve family therapy and or individual work and liaison within a multi-agency context.

The issue of patient confidentiality needed addressing at an early stage of the development of the service as the PMHS team were mindful that adult clinicians may not want to pass on concerns about their patients’ capacity to parent if they have little confidence in the resulting intervention by CAMHS and potentially risk the engagement of the patient (Cassell and Coleman, 1995). It was agreed that the joint assessment would be the place to negotiate this with the adult patient and, as our links and work with the different adult teams have developed, these sensitive issues become easier to address.

As well as attending the adult team meetings and finding out how the adult service worked, further links were and are being made. For example, nursing staff on the adult in-patient wards requested consultation about ways they might alter their assessment forms to include more specific questions about children. The adult duty service makes direct links to CAMHS when parents present in acute states and the newly appointed GP liaison nurses support our efforts to market the PMHS direct to primary care.

In response to the demand from the adult service, additional members of the PMHS team are now allocated to each adult community mental health team, with a fourth member of the team attending the weekly handover of the crisis resolution team.

Case examples
While most parents with mental health difficulties cope appropriately with the task of bringing up their children, for some families the presence of a mentally ill parent has a serious and detrimental effect on the children. This can take various forms, but at its most severe children can be neglected, abused and in extreme cases killed by their parents. The complex emotional tasks of parenting are readily affected when adults’ mental health problems disturb their emotional equilibrium, cloud their judgement and interfere with their reality testing. We will present three cases which demonstrate some of the issues.

Case 1
This involves a family from a war-torn country, who fled after the father went missing and applied for political asylum. The mother had functioned competently until these events, but became progressively depressed in the context of long delays in the asylum-seeking process and housing difficulties. She was eventually admitted to St Charles Hospital and was referred to the PMHS at the point of being discharged. There were three children, two of whom had left school and were studying at college, and a younger daughter halfway through secondary school. The concerns were about the effect of their mother’s depression on all the children, but particularly on the younger girl who had become withdrawn and sad.

In her depression, the mother had became emotionally frail, anxious and fearful, so that she was frequently in tears, constantly wrung her hands and was no longer able to deal with the demands of the outside world. Her use of English deteriorated and she reverted to her native tongue, in which the youngest child was not fluent, thereby reinforcing the
daughter’s feeling that she had lost her mother. All the children became anxious, tearful and angry, although the older two persisted with their education and took on many of the parenting tasks. However, all of the children’s education was affected to an extent and the family became increasingly isolated.

The focus of the family therapy work involved encouraging them to articulate their distress, to recount the events leading up to their flight and to begin talking about their father. They did not know whether he was alive or dead. The therapy also involved taking note of their strengths as a family, particularly their resilience and determination and the nurturing capacity of the older children. The team also wrote supportive letters on the family’s behalf, and supported them in changing to a new solicitor, who then undertook their case more effectively and also contacted their MP.

During the course of the work, after a sudden and enforced housing move, the mother became depressed again and was re-admitted to hospital. We were informed immediately of the mother’s admission by the team which had originally referred the family to us and visited her on the ward. Because of the disturbed nature of the wards, informal family sessions were held in the hospital grounds, and the sense of continuity which this provided seemed to help all the family members.

Case 2
This example involved a single mother with schizophrenia and her ten-year-old son. When the mother was floridly psychotic, she became deluded and had hallucinatory experiences. The delusions centred on her family relationships and her racial heritage, to the extent that she cut off all contact with her family and changed her own and her son’s names so that they reflected what she felt were her true origins.

The mother became convinced that her son’s skin colour was other than it was. When her symptoms were at their worst, she believed that any person of her race was an avenging member of her family, and she barricaded herself and her son in their home. Even when she was supposedly well, she had quite marked thought disorder.

Among the consequences of the mother’s illness was that the boy had missed about two-thirds of his schooling in the previous year, and had significant educational and developmental delay. The mother had also been targeted by a convicted paedophile, who had visited her at home, although there was no evidence that the boy had been molested. The son had also hurt himself when attempting to cook a meal for himself and his mother.

The effect of her illness on the mother’s parenting capacity was very marked and serious. She failed to recognise her son’s educational delay, failed to keep the necessary appointments with a speech therapist and also fabricated other problems about her son. Their social activities were extremely restricted, as a result of the mother’s own interpersonal difficulties, and she became very envious of any healthier relationships her son developed. Most seriously of all, she failed to recognise the risk to her son of sexual abuse from the paedophile.

The PMHS involvement in this case was to provide consultation to the adult team, who approached us with the question of how best to address the mental health needs of the mother, while also discharging their duty of care towards the son. Because of the mother’s social isolation, the team was mindful of the need to maintain her trust in the mental health team. An imaginative solution was reached, whereby it was decided that one person in the adult mental health team would attend the child protection meetings and provide the information necessary for social services to understand the son’s position, and to arrange the assessments necessary for his long-term care. Although the other members of her mental health team acknowledged the concerns about her son, they positioned themselves in such a way that the mother maintained her therapeutic relationship with them.

Case 3
This involves a request made by the adult service to the PMHS. Following a court
hearing where a single white mother, known to the adult services, lost care of her four children due to neglect and emotional abuse, a recommendation was made that the mother should receive therapeutic support prior to her contact visits with her children. There was a concern that the mother might behave inappropriately around her children, complaining about social services and inflicting further emotional turmoil on the children, as had happened at previous contact visits supervised by social services.

The adult team requested that the PMHS offer this intervention while being available for consultation about the mother’s psychiatric history. It was known that in the mother’s childhood consistent and brutal forms of physical, emotional and sexual abuse were experienced by her and her sister. She was identified as having a borderline personality disorder and had not engaged with the treatment she had been offered over time, despite repeated and tireless efforts by the adult service with whom she was often aggressive. Indeed social services had an injunction placed on her as she had attacked a member of staff at the recent court hearing.

Using a solution-focused approach, sessions concentrated on how this mother was going to draw on her capacity and resources to survive traumatic life events. She talked mainly about what had happened to her as a child, how she felt alienated from her own mother and her wish for a family. It was not possible for her to recognise how she was responsible in terms of her own children’s neglect.

Although the focus of the work was not actually looking at this adult as a parent, by talking about what it had been like for her as a child, which was what she wanted to discuss, she did begin to identify her resilience and think how this was going to help her withstand the loss of her children.

The liaison with the adult service to help the family therapist in the PMHS team develop an understanding of this mother’s diagnosis and varying presentation was critical in the approach to the work. It was not a service that the adult team could offer within their remit and following the first successful contact sessions this mother had with her four children, it may well prove a useful intervention for these ‘looked after children’.

Next steps
The PMHS team plans to capitalise on the collaboration that has been established with their adult service colleagues in order to approach further initiatives such as:

- meeting the next NHS modernisation agenda target, Early Intervention Psychosis, which would highlight the shortfall in adolescent in-patient service provision. Locally CAMHS are low on in-patient provision for older adolescents presenting with complex mental health problems and we rely heavily on the adult service to meet the needs of this younger population;
- widening the reach of the PMHS and marketing it to other service providers outside health including social services, education and the voluntary sector;
- reviewing/evaluating/auditing the PMHS activity, jointly, to illustrate and justify the need for the service.

With improved liaison between adult and child services and a significant increase in referral rates from the adult service to CAMHS, change is under way. The work of building our capability to meet the current level of demand is the next challenge. Indeed an audit was undertaken of the number of referrals coming into CAMHS from adult mental health services following the second approach made to the adult service. It transpired that, over a period of five months, there were 80 referrals of children of parents with mental health problems who had some form of input from CAMHS, be it for consultation, for on-ward referral, ongoing work at Parkside Clinic or joint work at St Charles Hospital.

Conclusions
How might our experience of developing this service contribute to current thinking about effective methodological approaches
to joined-up service provision? What made it possible to design an emergent and responsive service to suit the local conditions and enable families access to a more co-ordinated service?

Our conclusion is that certain conditions were in place that enabled the implementation of the service (Anderson-Wallace et al, 2001). Resources were made available to the PMHS by the local health authority to fund a family therapy post. With a mandate to work flexibly at the service interface, the family therapist was able to design an emergent and responsive service, drawing on a pragmatic approach proven to be effective in such complex organisational settings where the need for change is compelling (Anderson-Wallace et al, 2001).

While it was clear that the adult and child teams did have different contributions to make to the development of the PMHS, there was common ground about the critical need to work jointly with these families. Agreement on methods to put collaboration into practice was reached through conversations that took place at team meetings, through joint case work and discussions about shared cases.

In addition, there was a view held within the PMHS team that spending time building relationships with colleagues in the adult service through the clinical work, and being on site learning about their context, were essential if the service was to be viable. This would suggest that in order to effectively ‘join up’ services it is necessary for staff to have the resources available so that steps can be made in order to do the work together at the interface.

With adult and child services providing joint work using a more family-focused approach, the aim is that adult patients are asked about their children at the point of referral and about the sorts of supports they have created themselves or would indeed value. In this context, parental anxiety about the unnecessary removal of children can be addressed and in most cases appropriate services can be made available, thereby lessening the need for statutory intervention.

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References
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