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'Whose baby is it anyway'

Developing a joined-up service involving child and adult teams working in a mental health trust.

This article describes how clinicians from a child and adolescent mental health service (CAMHS), based at Parkside Clinic in North Kensington, 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 based at St Charles Hospital.

The service came to be known as the Parental Mental Health Service (PMHS) and its remit 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.

Through a description of how the service developed, we will draw attention to key learning points and will identify the sources we have drawn on including: 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 two members of the team, the Consultant Child Psychiatrist, Dr Clive Britten and Amynta Cardwell, Senior Family Therapist.

The Context

The findings of research carried out by the NSPCC in 1997, involving a small sample of parents with mental health problems in Brent, bore out a familiar hypothesis that adult patients believed that if they became unwell they faced the threat of their children being taken into care. 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 and in the cases we saw where a parent had a mental health issue. We were particularly struck by the following questions;

- 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 childrens' needs and to maintain networks of support which they can draw on if they become unwell?

- What might have been different for the adolescent, presenting with problems related to fat-phobic attitudes, if the services offered to their parent, also suffering from an eating disorder, had been co-ordinated within a multi-agency context

including health visitors, paediatricians, G.Ps and adult services? Who was responsible to act on and make the link between the needs of this developing child and their parent's relationship to food ?

- ♦ 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 their 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 their parent is admitted for in-patient treatment and how might this explanation, the process and the content, impact their sleeping difficulties at their foster carers?

- ♦ How is it that the referrals we were receiving, involving allegations of child abuse, didn't routinely include relevant information about a parent's psychiatric history?

This latter question was of concern particularly in light of Adrian Falkov's analysis in 1996 of 100 Fatal Child Abuse Case Reviews. He concluded that 25% 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 5 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 insufficient.

With all of these questions in mind we were aware of the compelling need to direct services towards this client group.

In the wider community, literature and research were already pointing to these questions and accompanying issues, and in particular the extensive work carried out by Reder et al (2000) in this field culminating 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 effecting their capacity to parent.

Hodes (2000), has a special interest in the relationship between 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.

A central point Reder and Duncan (2000) make 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 therefore should be given to the sorts of behaviours a child is subjected to from their carer rather than assuming that by identifying the diagnosis of the adult the risks to the child are clear. Also the authors 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?

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.

Falkov (1998) cited statistics looking at in-patient admissions, and that women between the ages of 20-40, traditionally most responsible for child care, make up 20% of all in patient admissions.

Other factors informing the context were the NHS policy documents that were pointing to the need for service providers to address the issue of working across traditional organisational boundaries. The aim was to improve service provision for children and families, for example the Department of Health (1999) publication. Working together which makes special reference to the needs of children being cared for by a parent with a mental illness.

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 within Trust Management that the Parental Mental Health Service was a pragmatic and timely service offering.

However it was also recognised at senior management level within our mental health Trust, 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 task of 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).

Whilst 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 3 community mental health teams (CMHT), a Crisis Resolution Team (CRT), 3 in patient wards, a 24 hour duty service, a day hospital and an out-patient clinic.

The Parental Mental Health 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 from CAMHS and the NSPCC who 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 with the adult mental health teams so that the conditions were in place to provide adult mental health services users known to have children with the following;

- direct clinical work for parents and their children – with clinicians drawing from a range of approaches subject to 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 adult services.

Initial approaches and interventions.

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

- the Parental Mental Health Team visited the 3 different adult mental health teams to market the service and proposed referrals came directly to the service rather than being referred back to the GP.

- Joint training was put on for adult clinicians – looking at child protection in the context of parental mental illness.

- A multi-agency forum Parkside Clinic offered practitioners from adult and child services an opportunity to discuss cases where there were concerns about parental mental health issues.

- A free-lance 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, there was no significant increase in the referral rates of children from the adult service and no obvious difference in the way the 2 teams liaised about cases.

Engaging the 3 Adult Community Mental Health Teams would require a different approach, and resources were directed toward funding a family therapy post, with the brief 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 (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 M, Blantern C and Lejk A., 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, on-line and or through questionnaires that focus on the diverse priorities and varying contributions of all key stakeholders and finding ways to co-ordinate activities accordingly; This became the model for developing the PMHS.

These ideas led to a further intervention being made to the adult team by the family therapist, hoping to address how CAMHS might alter their service offering in order to give the aims of the PMHS a better chance of success.

The family therapist approached clinicians and managers within the CMHTs and other departments in the hospital and set up an enquiry consisting of whole team interviews and questionnaires: the aim was to learn more about the adult context and hear directly from clinicians how we might best work together.

Through discussions and written comments there was an acknowledgment that our efforts to work collaboratively together in the past had not always been successful. Naming this set a context for a discussion about how this joint service might create a useful opportunity to do things differently and to build 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 service could be of use to the patients of the adult service, that designated resources were on offer, and that CAMHS were going to design the service with adult colleagues, it then 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 at each weekly adult mental health team meeting would ensure that appropriate cases could be picked up at the point of referral. The Parental Mental Health Service therefore became a part of the weekly agenda of the CMHT meeting.

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 would consult to the family therapist about the adult patient and in turn the family therapist consulting about the relevant child mental health issues. Conversely, cases known to children's services, where there are concerns about an adult mental health issues, are brought to the CMHTs and in this way treatment can be co-ordinated across the separate services.

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

- The sorts of behaviours a child living with a referred adult might be subjected to
- whether parents or professionals had any concerns about a child
- to identify coping strategies and resources of the adult patient
- To identify networks of family, cultural religious and professional support
- To offer ongoing work at Parkside Clinic and/or refer elsewhere where appropriate
- To respond to child protection issues, by referring and liaising with social services where necessary.

It is set out in the PMHS referral policy that following the assessment clinical responsibility for the adult patient resides with the adult team whilst 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 the early stage of the development of the service as the PMHT were mindful that adult clinicians may not want to pass on concerns about their patients' capacity to parent if they had little confidence in the resulting intervention by CAMHS and potentially risk the engagement of the patient. (Cassell & 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 has 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 make direct links to CAMHS when parents presented in acute states and the newly appointed GP liaison nurses support our efforts to market the PMHS direct to primary care.

There was no request to CAMHS for further formal training in child mental health issues from adult clinicians or managers.

An agreement was reached that the joint working and shared case consultation that took place would be a more pragmatic means of enhancing skills for both child and adult staff.

In response to the demand from the adult service, additional members of the PMHT are now allocated to each adult community mental health team with a forth member of the team attending the weekly hand over 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 as mentioned above. 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 judgment, and interfere with their reality testing.

We will present two cases which demonstrate some of the issues.

Case one
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 the long delays in the asylum-seeking process, and housing difficulties. She was eventually admitted to St Charles, 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 her 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, whom 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. We also wrote supportive letters on their behalf, and supported them in changing their 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 readmitted to St Charles. 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 two
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 origins, to the extent that she cut off all contact with her family of origin, 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 was quite markedly thought-disordered.

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. He 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 recognize her son's educational delay, and 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 recognize 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 both 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 the mother's trust in her 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 three
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 4 children due to neglect and emotional abuse, a recommendation was made that the mother should receive therapeutic support prior to her 3 contact visits a year with her children. There was a concern that the visits might create a context where the mother behaved 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 the PMHS offer this intervention whilst 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 focused on how this mother was going to draw on her capacity and resources to survive traumatic life events. She talked mainly about what happened to her as a child, and how she felt alienated from her own mother and her wish for a family. It was not possible for her to recognise what and 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.

This work is ongoing and we will focus on how this mother is able to be a good enough parent in the context of the contact sessions albeit 3 x a year.

The liaison with the adult service to help the family therapist in the PMHT 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

Whilst continuing to co-ordinate the PHMS development with the priorities of the adult service, the Parental Mental Health Team plans to capitalise on the collaboration that has been established with their adult colleagues in order to approach further initiatives such as;

- Meeting the next NHS Modernisation Agenda target, that of Early Onset Psychosis, which would create the opportunity to look at the short fall 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 Parental Mental Health Service 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 underway. 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 AMHS following the second approach made to the adult service. It transpired that there were 80 referrals of children of parents with mental health problems who had some form of in-put from CAMHS be it for consultation, for on-ward referral, ongoing work at Parkside Clinic or joint work at ST Charles.

Conclusions

How might our experience of developing this service contribute to the thinking currently underway about effective methodological approaches to interface working and 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. Resources were designated to the Parental Mental Health Service by the local Health Authority to fund a Family Therapy post. With a mandate to work flexibly at the interface the family therapist was able to design an emergent and response service in context, 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)

Whilst it was clear that the adult and child teams did have different contributions to make to the development of the PMHS there was a shared agreement that the need to work with these families was critical. This agreement was reached through conversations that took place at team meetings, through joint case work, discussions about shared cases.

In addition there was a view held within the PMHT that spending time building relationships with adult colleagues through the clinical work, and being on site learning about their context was 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 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 most cases appropriate services can be made available, thereby lessening the need for statutory intervention.

Key words
Parental Mental Health Service, relational effects of adult mental health, systemic family therapy, designing a service in context, pragmatic approaches to cross-boundary working, multi-agency networks and joint working

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Amynta Cardwell, Systemic Practicioner, has developed her clinical and strategic role at CNWL and her work has been informed by her association with Inter-Logics, a group of researchers specialising in pragmatic approaches to cross-boundary working.

Dr Clive Britten, Consultant Child and Adolescent Psychiatrist, was employed by CNWL Trust till August 2002. His special interest in parental mental health services is informed by his work with adults at C.G. Jung Clinic, which is aphiliated to the Society of Analytical Psychology.

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