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Consultation to adoptive parents and adoption professionals in child and adolescent mental health: findings from a quality improvement project analysis

The mental health vulnerability of children and young people in foster and adoptive families is well recognised, which has led to the development of dedicated posts and care pathways in mental health care provision. This article reports on learning resulting from local quality improvement work in a single child and adolescent mental health service team concerned with the 'front door' of access to care for these groups. It specifically addresses initial consultations with adoptive parents and adoption professionals, reporting findings from an analysis of consultations undertaken over a 13-month period between April 2021 and May 2022. The analysis highlights that support from mental health services can be sought by these parents and professionals for diverse issues relating to mental health. This indicates the high level of need displayed by children and young people involved with specialist mental health provision. The analysis also has wider implications for practice in demonstrating the benefits of attending to clinical data to contribute meaningfully to practice-based scholarship in this type of specialist setting.

Keywords: adoption, child and adolescent mental health, consultation, COVID-19, parenting, quality improvement

Introduction

The mental health vulnerability of children and young people in foster and adoptive families is well recognised, with between one third and half of children and young people in this population estimated as having a clinical-level of mental health need, as well as increased levels of additional health needs, including both moderate and severe physical health problems, and learning disabilities (Duncan et al., 2021; Tarren-Sweeney, 2019). Consequently, in the UK, dedicated service provision has been developed, including designated care pathways and posts in National Health Service child and adolescent mental health service (CAMHS) provision (Archard et al., 2022a, 2022c; Deuchar & Majumder, 2021; Miller et al., 2023). While these pathways and posts help to support timely access to care, it is important that local health organisations delivering the services understand the contextual issues pertinent to their delivery of care, specifically accounting for factors that influence the needs of the local population being served. Indeed, waiting times to access child and adolescent mental health care can be considerable (Crenna-Jennings & Hutchinson, 2020), and there are gaps in specialist provision across areas, with a paucity of services for very young children (Moriarty et al., 2016). Moreover, adoptive and foster parents are known to report feeling judged by professionals when seeking support (Archard et al, 2022b; York & Jones, 2017).

Against this backdrop, practitioner-initiated evaluation projects connected to quality improvement endeavours have real-world value. Not only can they illuminate practice issues, this kind of work can also aid in understanding the experiences and needs of children, young people, and families, and the effectiveness of clinical interventions considering available empirical evidence, practice guidance and care delivery at a local level. Further, by sharing such evaluation projects more widely under the quality improvement rubric, other health

organisations can map ways in which to undertake their own learning about such matters and design their own work to address similar concerns.

This article reports on learning resulting from quality improvement work concerned with the 'front door' of access to CAMHS care for adoptive and foster families. The work was undertaken within a single specialist team serving children and young people who are adopted and who are care-experienced, as well as other populations considered vulnerable to a high level of mental health need. Specifically, the quality improvement work was linked to the ongoing development of a practitioner post in the team. This post, which was designated for a senior mental health nurse or social worker, directly concerned adoption and support for foster and adoptive parents.

A focus of this quality improvement work was initial consultations with adoptive parents and adoption professionals. This article reports an analysis undertaken as part of it, attending to child/young person characteristics, professional and parent concerns, and patterns of referral onwards for triage assessment. The article is organised in the following way. The function and typical structure of consultations is discussed first, then the aim of, approach to and findings of the analysis are reported. Thereafter, the implications of these findings for practice learning and future research are considered.

Consultations with adoptive parents and adoption professionals

Consultations for parents and professionals also comprise an essential component of therapeutic and mental health service provision for children and young people in foster and adoptive families (Clare & Jackson-Blott, 2023). Consultations serve as a form of intervention, via joint enquiry and exploration of issues, with guidance being given to indirectly benefit a child or young person. Due to a reduced time commitment involved for mental health professionals, they also enable a larger population of children and families to

be reached by a service. For professionals and parents accessing them, they can helpfully provide reassurance in understanding children (Archard et al., 2022a). Consultations also function as a gateway to in-person – that is, initial triage – assessment prior to psychological therapy, pharmacological treatment or signposting to other agencies/support.

In the case of the consultations provided through the adoption lead role, these were available to parents and professionals via a dedicated clinic or on ad-hoc basis through a longstanding commissioning arrangement between the specialist CAMHS team and the local county council adoption support and placement services. The consultation model was based on a consultee-centred approach (Caplan, 1970), incorporating aspects of an integrative mentalisation-based framework, which is rooted in Bowlby's (see Bowlby, 1969, 1973, 1980) attachment theory and its expansion by contemporary developmental psychologists and neuroscientists (Malberg, 2015).

A single consultation typically lasts between 45 and 60 minutes and involves:

- Clarification regarding the purpose of the consultation, expectations around the sharing of information.
- Discussion (30- 40 minutes) regarding the concerns of the parent/s and professional/s in attendance regarding the child/young person.
- Summative observations and recommendations and formulation of a plan for next steps.

Documentation

The content of the consultation is routinely textually recorded in the form of a two-to-eight-page report, which is sent out in letter form to the attendees shortly afterwards via post or email. The report letters are authored by the adoption lead, but support is often provided by

junior colleagues who are either student mental health nurses or trainee or assistant psychologists. These colleagues provide additional support with questioning in the consultation and can take detailed notes.

The letter has a dual function: it is a working document for a parent or professional to return to and make use of, and it is a means of imparting information to colleagues in mental health and therapeutic services for subsequent assessments or support.

Aim

The aim of this quality improvement project was to use the report letters, as routinely collected clinical data, to examine the nature of the concerns raised by adoptive parents and adoption professionals for which CAMHS input was sought, as well as child/young person characteristics and needs and, patterns of referral for triage assessments.

Method and materials

The report letters used for the analysis concerned consultations over a 13-month period between April 2021 and May 2022, following the onset of the COVID-19 pandemic and lockdown periods in the UK. During this time, all consultations were facilitated online via videoconferencing.

The analysis was undertaken by clinical and clinical support staff who took responsibility for the management of the data based on a clinical data mining methodology to aid service improvement (Epstein, 2009). Guidance was provided by colleagues in psychiatry and psychology with research and quality improvement roles in the National Health Service Trust in which the service is based, as well as academic institutes within whom there were established links from prior collaborative endeavours.

To analyse the consultation reports, data were transferred into a spreadsheet for comparative review, using different categories, subcategories, and content analysis (Braun & Clarke, 2006).

Ethical considerations

To ensure the analysis was conducted in an ethical way, a proposal and protocol for the work were submitted for review by the quality improvement department in the wider NHS trust, with the project being categorised as service evaluation work to support local iterative care improvement. Moreover, in accordance with quality improvement ethical adherence, where clinical data was abstracted for the purposes of analysis, identifying information was removed.

Findings

Via the analysis, six themes were identified. These concerned attendees at the consultations, principal or presenting concerns, child/young person difficulties and needs, adverse childhood experiences, clinical measures and questionnaires, and consultation outcomes/referral onwards.

Attendees

Twenty-nine consultations were conducted, comprising 26 initial consultations and three follow-up consultations for 31 children/young people in total. Four consultations concerned sibling groups of two or three children/young people.

Of the total 29 consultations, in 23, at least one adoptive parent attended. On 13 occasions, two adoptive parents attended together, and social workers were present in 23 consultations, and a counsellor in one - see Table 2 for frequencies. In three of the

consultations in which only one adoptive parent was in attendance, either alone or alongside a social worker, and only on one occasion was this a father.

<Insert Table 1 approx. here>

Principal concerns

Of the 29 consultations, two of the consultations were accessed by social workers seeking professional advice relating to children/young people's emotional wellbeing in the context of placement transitions from foster care to adoptive families.

In the other 27 consultations there were a range of reasons CAMHS input was requested. Primarily, as was the case for 20 consultations, this was for help in considering next steps/action to take regarding a child or young person. However, this could entail a range of issues, notably, the value of long-term psychological therapy or life-story work (two consultations), thinking about how to manage specific behaviours (three consultations), and the potential need for psychiatric assessment (two consultations for three children/young people).

Child/young person difficulties and needs

The 27 consultations concerned 27 different children/young people aged between three and 15 years: 15 (55.56%) male and 12 (44.44%) female children/young people. For both groups, mean and median ages were comparable: the mean age for male children/young people being 8.47 years and median age, nine, while for the female children/young people, the mean age was 9.33 years and median age, eight.

In the case of all 27 children/young people, some form of attachment difficulty and/or attachment adversity was reported premised on discussion regarding the child/young person

during the consultation. As the letter was the mental health professional's report, this was hypothesised by them, albeit via discussion with the parents/post-adoption social worker, with them (potentially) using the language of attachment or describing the relationship between parent and child/young person.

Outside of concerns regarding some form of attachment difficulty and/or attachment adversity, concerns relating to affective dysregulation and physical aggression were most prevalent, described in relation to 15 and 12 children/young people respectively, with physical aggression much more often identified in relation to male (11 children/young people) than female children (one child). As a category, physical aggression covered a range of behaviour including engaging in 'dangerously silly behaviour' leading to increased potential for accidents/harm (two children) and a child punching, kicking, or biting adoptive parents when their wishes were thwarted in some way (five children/young people) – i.e., as forms of child to parent violence.

<Insert Table 2 approx. here>

Various other difficulties were also evident (see Table 1 for those that were most common). These included: difficulties navigating relationships with peers and sustaining friendships - nine children/young people; six female and three male; 'attention-seeking' behaviour - eight children/young people; five male and three female; self-injurious behaviour - five children/young people; four male and one female, ranging from the punching and biting self, headbanging against walls or floors, to skin picking and excessive scratching; and intentional self-harm - two female children/young people, in the form of the ingestion of nail polish and the cutting of skins using sharp objects. There was also comment on difficulties with eating/food - six children/young people: five female and one male; described in terms of

‘painfully slow’ eating habits and fussiness surrounding certain foods, and issues with sensory processing - six children/young people; five male and one female, including hypersensitivity to texture and noise.

Reference was also made to difficulties with sleep - five children, four female and one male, including struggling with separation from parents at night, recurrent nightmares, and consistent waking during the night; demand avoidance - four children/young people, three male and one female; and for single children/young people (all male), obsessive and ritualised types of behaviour, expressions of suicidal ideation, and sexualised behaviour.

Four children/young people were described as highly anxious, three as needing almost constant levels of supervision and attention, and five as presenting as noticeably younger than their chronological age in their behaviour and/or level of academic attainment and behaviour - three male and two females. In the case of four children/young people, concerns regarding actual or possible attention deficit and hyperactivity disorder or attention deficit disorder were expressed - three male and one female, with three children having prior diagnoses of attention deficit and hyperactivity disorder and the other being described as displaying characteristics associated with the disorder. A birth family history of autism/autism spectrum disorder was also mentioned in relation to two male and two female children/young people.

Typically, multiple difficulties/concerns were evident together. Ten/young people children were described in terms of four of the above difficulties/concerns, nine in terms of five, and only four children in terms of six or seven. Only four children/young people overall displayed three or less of these difficulties/concerns.

With respect to commonalities amongst different subgroups of children/young people, physical aggression was much more evident amongst male children aged seven to 12 years, accounting for seven of the 12 children/young people who were described in terms of this difficulty. Self-injurious behaviour was primarily represented in four- to six-year-old

children, but also two male children in the seven- to 12-year-old age range. Self-harm was reported in the cases of two adolescent females. Five out of six of the children identified as displaying difficulties with eating/food were female, and primarily in the seven- to 12-year-old age range.

Difficulties navigating relationships with peers and sustaining friendships were also more common amongst female children/young people and spanned the ages seven-18-years. Issues with affective dysregulation were most common amongst latency aged children – 7-12 years. Self-injurious acts and displays of physical aggression were also often present alongside difficulties with affective dysregulation.

Multiple comments were also recorded in the consultation reports about the impact of children/young people's difficulties on parents and the family home. This included specific comment on high levels of stress and worry for parents.

Adverse childhood experiences

A structured questionnaire regarding childhood adversity was not used in the consultations. However, background information recorded indicated that this was experienced by many of the children/young people prior to adoption.

Felliti et al.'s (1998) taxonomy of adverse childhood experiences identifies core factors that have been found to correlate with a range of poor health and psychosocial outcomes throughout the life course. Based on this taxonomy, a range of childhood adversity was evident in the children/young people's individual backgrounds. Birth parent substance misuse was evident in respect of 12 children/young people, domestic abuse for nine, family mental illness for nine, emotional neglect for seven, physical neglect for seven, physical abuse for seven and emotional abuse for three. Parental separation/divorce was mentioned in the case of two children.

Measures/questionnaires

Clinical measures and questionnaires were referred to relatively infrequently in the consultation reports, for six consultations in total. The measures that were referenced comprised those more commonly used in CAMHSs in the UK to screen for neurodevelopmental conditions and common mental health disorder.

For three consultations, the Revised Children's Anxiety and Depression Scale was used - a 47-item, self-report questionnaire with subscales covering common emotional and mental health difficulties (Chorpita et al., 2000; Spence, 1997). In both cases, this was sent out to be returned by post prior to an initial in-person triage assessment.

In two consultations, the Strengths and Difficulties Questionnaire was used (Goodman, 1997) - a brief, widely used behavioural screening questionnaire that can capture the perspectives of children and young people, their parents, and teachers (Vostanis, 2006). In both cases, the parent version was sent out.

Alongside this, to screen for suspected neurodevelopmental conditions, i.e., of autism spectrum disorder, attention deficit disorder, attention deficit and hyperactivity disorder, the Social Communication Questionnaire (parent version) (Rutter et al., 2003) and Conners Comprehensive Behaviour Rating Scale (parent and teacher versions) (Conners, 2008) were used on two occasions, either being sent to a parent or school staff. These were to complete prior to a follow-up consultation or in-person assessment. In one consultation, the use of the Coventry Grid (Moran, 2010) was mentioned as means of considering, as the measure is designed to address, the extent the child's presenting difficulties were indicative of autism spectrum disorder or attachment difficulties. This was in the context of the measure being used prior to the consultation by the attending social worker.

Outcomes/referral onwards

Fifteen of the children/young people for whom consultations were completed were referred on directly for an in-person triage assessment with the specialist CAMHS team. The demographic characteristics of this group broadly reflected those of all 27 children/young people for whom consultations were sought, with eight male children with a mean age of 10.25 years and age range or five to 15 years, and seven female children, with a mean age of 9.43 years and age range of six to 14 years, referred on. Most of these children/young people, that is 13 of the 15, were, at the time of the consultation, receiving some form of professional support or therapy outside of CAMHSs. In several of the consultation report letters, recommendations were made about parents accessing services themselves via some form of family support, respite care, or parenting input due to the impact of the child/young person's situation or difficulties on parents.

Interestingly, a child/young person was more likely to be referred on for triage assessment following attendance by two adoptive parents together rather than if a single parent attended alongside a social worker, or a social worker or adoptive parent attended alone. That this was the case in 10 of the 15 consultations completed with two parents, suggesting that the joint presence in the consultation may, in some way, compel this referral, which may be helpfully explored via future research.[1]

With respect to specific assessments requiring completion following the triage assessment, reference was made to a cognitive assessment for a possible intellectual disability/functioning impairment, psychiatric assessment for reactive attachment disorder, and assessment for suspected neurodevelopmental disorder.

Discussion

The findings of this analysis highlight how CAMHS involvement can be sought by adoptive parents and adoption professionals for a diverse range of issues relating to mental health and emotional wellbeing, as well as children/young people's development and psychosocial risks in children's and families' lives. Consistent with knowledge from existing literature (Tarren-Sweeney, 2019), the analysis found that the level of mental health need overall appeared high, with children/young people for whom consultations were sought displaying a wide range of difficulties. Requests for CAMHS help in relation to externalising difficulties, especially physical aggression, were more commonly reported for male children. These difficulties in boys tend to be comprised of visible challenging behaviours that can raise the demand for urgent professional help, assessment, and possible intervention. The more invisible internalizing symptoms in female children/young people may mean that their difficulties go undetected by parents and services, or that there is insufficient consideration of associations between life events and subsequent mental health symptoms (Prock & Fogler, 2018). Moreover, the high levels of mental and behavioural needs of children/young people who are adopted can be considered in terms of the seeking of support across a range of mainstream agencies, and level of stress experienced by parents which was likely compounded by the effects of the pandemic and can be higher amongst adoptive parents (Christie et al., 2022; Harris-Waller et al., 2016; Skripkauskaite et al., 2023). This may explain why many of the children/young people referred on via the consultation for in-person triage assessment were receiving some form of support outside of CAMHSs at the time of the consultation. There remains a significant challenge to develop shared understandings in practice between parents, children, and mental health services of adopted children's needs, not least owing to the absence of data about adopted children's mental health (O'Reilly et al., 2016; Woolgar et al., 2023).

Considering the apparent level of complexity of need with children/young people along with what is known from other research about differences in understanding between professionals and adoptive parents has certain implications for practice (O'Reilly et al., 2016; Woolgar et al., 2023). Notably, the findings of the analysis provide further support to proposals that CAMHSs professionals, including social workers and mental health nurses, require specialist knowledge and skills when working with adoptive families, including in the practice of consultations. The findings also highlight the need for active ownership of this client group by CAMHS, tertiary therapeutic services, and local authority social care services together (Ratnayake et al., 2014). This should be supported consideration by services of the effect that joint working and interagency collaboration has on overall outcomes for children and families.

Concerns have been expressed by practicing clinicians about the deployment of ideas relating to attachment adversity and the development of psychopathology in care-experienced and adopted children, with more common psychiatric and neurodevelopmental conditions being overlooked in favour of nebulous notions of developmental trauma (Woolgar & Scott, 2014; Woolgar & Simmonds, 2019). With this, it is important to recognise that consultations with parents and/or professionals in CAMHSs are just one element of the process of assessment and support, typically preceding more comprehensive investigations. Thus, care should be taken in considering what is possible to achieve in a consultation alone. Careful history taking enables insight into how parents understand and speak about their children and to consider the trajectory of a child's development and changes over time so that different reasons for specific behaviours can be properly weighed up, and the severity of the difficulties assessed (Prock & Fogler, 2018).

Thought can also be given to the utility of different clinical measures for screening for different conditions with specific populations prior to, following on from or as part of

consultations. For instance, although the Social Communication Questionnaire is a widely used screening measure for the assessment of autism spectrum disorder, its specificity and sensitivity in use with older children in the context of community CAMHS provision is unclear (Hollocks et al., 2019). Taking this into account, specialist training for professionals appears important, but this must be based on dialogue between research and practice communities, particularly issues of differential conceptualisation regarding neurodevelopmental conditions and trauma-based presentations and attachment difficulties (Coughlan et al., 2022; Woolgar, 2013).

Methodological considerations

For the analysis, consultation reports were reviewed in depth primarily as a means of learning from experience via an analytic orientation to practice (Shaw, 2004; Lunt & Shaw, 2017). Detailed analysis of the material gathered was realised, but this was based on a modest sample, from one service in a single NHS Trust for local service evaluation and therefore avenues are needed to develop the work further.

This limitation notwithstanding, at its simplest, sharing lessons from localised quality improvement work creates and encourages open discussion across services and recognises the value in motivating other clinicians to interrogate their local data in this way. Quality improvement dialogue for organisational learning is a foundation for practice-generated questions and concerns, which can usefully contribute to the literature as well as providing a basis for the generation of important questions for future exploration through rigorous research designs (Matulis & Manning, 2023). The involvement of junior colleagues and trainee professionals also helps to demystify ideas around evidence-informed practice and prepare a workforce that learns about the process of evaluation in a practical, applied fashion (Appleton et al., 2016).

The arguments based on the analysis illustrate some of the value of this type of clinical data mining approach as a methodology to fill a gap between empirical research and care delivery alongside other forms of engaged practice-near scholarship (see, e.g., Epstein, 2009; Pritchett & McGarry, 2022). This kind of work helps organisations to identify contextual and organisational issues that require attention or change so that they can be responsive to population need and, more broadly, to develop a language regarding what constitutes practice expertise in a particular area of care delivery.

Note

1. For example, the presence of both parents may be interpreted by a mental health professional as an indication of the significance of the challenges they were facing and a unified responses that adds weight to the case. Alternately, or additionally, it may be that more detail is yielded from two parents over one or indication of a gender bias that, if the father attends, his version is somehow perceived subconsciously as more credible by the professional.

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Table 1: Consultation attendees

Group	Frequency
Adoptive mother	24
Adoptive father	12
Social worker (post-adoption support or permanency planning)	28

Table 2: Recurrent child/young person difficulties/needs

Difficulty/need		Split by gender	
	Frequency	Male	Female
Attachment adversity/difficulties	27	15	12
Affective dysregulation	15	10	5
Physical aggression	11	10	1
Difficulties navigating relationships with peers	9	3	6
'Attention seeking' behaviour	8	5	3
Difficulties with eating/food	6	1	5
Sensory sensitivities	6	5	1
Difficulties with sleep	5	1	4
Self-injurious behaviour	5	4	1