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Child and adolescent mental health services liaison with primary care services: a training opportunity in consultation

Consultation is an important means of service delivery for child and adolescent mental health teams, and this is recognised in a number of recent national documents. For the past 6 years, a formalised training opportunity with a local child and family social work team has been in place on the West of Scotland higher specialist training rotation. The consultation process is described, highlighting the mutually beneficial relationship that has developed for both agencies.

Consultation with primary care services – also called 'tier 1' services by the National Health Service (NHS) Health Advisory Service and defined as 'agencies that offer first-line services to the public and with whom they make direct contact', such as general practitioners, health visitors, teachers and social workers (NHS Health Advisory Service, 1995) – is an increasingly important part of the work undertaken by child and adolescent mental health services (CAMHS) today (NHS Health Advisory Service, 1995; Audit Commission, 1999; Public Health Institute of Scotland, 2003). Consultation is defined as 'a shared exploration with other professionals of problems and possible solutions in which the consultant facilitates the problem solving process for another professional or group' (Royal College of Psychiatrists, 1999). It is desirable that new consultants in child and adolescent psychiatry are equipped with the skills necessary for this way of working and, reflecting this, consultation is an educational goal identified by the Royal College of Psychiatrists (1999) for higher specialist training. In recognition of this, an arrangement was made by the tutor for the West of Scotland higher specialist rotation in child and adolescent psychiatry and local social work managers to develop a training opportunity in consultation for specialist registrars.

Since 1998 a specialist registrar has provided informal consultation to a child and family social work team based in the south of Glasgow. The 'informal' nature of this arrangement distinguishes it from the consultation services offered by the CAMHS team for the area, to whom 'formal' referrals would be made. The service is 'independent' in that the specialist registrar undertaking consultancy is not attached to the local CAMHS team. In addition, a consultant psychiatrist located outwith the catchment area, with an interest in systemic practice, provides regular supervision. The benefit of this arrangement is that there is no expectation for the trainee to assume clinical responsibility for cases brought to discussion, and the focus can be more on the consultation process itself.

Organisation and practicalities of the consultation service

Consultation can be provided in a variety of ways: group or individual; fixed session or on demand; clinical-based or area office-based (Appleton, 2000). The consultancy service offered by trainees has varied since its inception according to the trainee's level of experience and the needs of the social work department. The general arrangement has remained constant, with a dedicated session at the social work team base one morning every 4–6 weeks. At present a 30 min appointment system is used for discussions with individual social workers or co-workers. The whole process is overseen by a senior social worker. It is anticipated that cases brought for consultation will have been discussed in advance with the relevant senior social worker and that questions about possible mental health issues remain. The approach aims to be as relaxed and unthreatening as possible, to encourage social workers to bring cases they might not take to formal consultation. Specialist registrar trainees keep simple written records, for the purpose both of supervision and of future reference, because many social workers who attend return later to give feedback on progress. Earlier approaches have included group discussion of individual cases, and attendance by the senior social worker with case management responsibility. However, although these approaches offer different kinds of consultation experience to the trainee and social work colleagues, increasing pressure of time on individual

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social workers has led to the current individual appointment system prevailing.

Supervision of the trainee is provided on a 3-monthly basis by a consultant child psychiatrist with training in systemic practice. During supervision, cases are discussed with the focus on the consultation process, rather than the clinical content. Through this, an increasing awareness of boundary issues, effective inter-agency working and reflexive practice is developed.

Since the scheme's inception 6 years ago, five specialist registrars have taken up this training opportunity. During the 15 months that I provided consultation to the team there were a total of 43 contacts: 31 were single consultations about a family or young person; three social workers returned on two occasions to discuss the same family; and two families were each presented three times (one of these including a change of allocated social worker). A wide variety of issues were brought to consultation, including concerns about parenting and child development, discussion about appropriate placements and legal processes (including child protection issues), and mental health concerns about carers and children.

Discussion

Although the consultancy service was originally set up for the benefit of psychiatry trainees, it has become apparent that this forum offers gains (despite presenting challenges) to both professional groups. For the psychiatrist, the service provides a valuable experience in consulting with professionals in the primary care setting. Trainees develop an acute awareness of the difficulties facing social work staff in the light of increasingly limited resources for complex cases. There is a challenging learning experience in providing consultation without taking on a supervisory role. Consulting on a family already under review by the local CAMHS team needs to be managed with sensitivity, including the establishment of transparent communication between the two agencies. The social work team describe considerable benefit from an informal consultation service which can improve care plans. Through consultation, social workers improve their awareness of the impact of mental health issues within the family setting, thereby influencing their practice and guiding patterns of referral to the CAMHS team. The experience of consultation has generated 'in house' training sessions, e.g. on attachment theory and motivational interviewing. Areas of resistance demonstrated by social work colleagues who attended for consultation included a reluctance to manage time and an anxiety about the perceived scrutiny of their practice. Such resistance becomes more entrenched if the forum takes a group format.

The attendance of a senior social worker during consultation has proved to be very useful. For the specialist registrar, discussion is facilitated about issues relevant to social work practice. The pressure on the specialist registrar to take on a supervisory rather than a consultatory role is alleviated, and a thread of continuity is provided through a sequence of social work case managers. A disadvantage is that social work colleagues may feel uncomfortable about their senior manager scrutinising their practice; if this is not handled in a sensitive and supportive manner, the consultation service will be used much less frequently.

While acknowledging these potential challenges, the obvious gains of this informal consultation service seem to echo the comments of Richardson & Partridge (2000), who highlight the advantages of the consultation process in fostering an improved tiered system with better communication, better understanding of the respective roles of staff and improved quality of referrals.

This consultancy service, which is unique in Glasgow, is viewed with some envy by other social work child and family teams in the city, who wish to experience its informality and accessibility. While a significant factor in the success of the current arrangement has been that consultation takes place in the social work base, thereby allowing a greater number of social workers to attend, the committed presence of a senior member of social work staff during these sessions would be of added benefit for higher specialist training purposes. Although the consultancy service is considered to be valuable, formal evaluation has been difficult because records are not kept by consultees on the families discussed. This will need to be addressed for future review.

Examples of cases brought to consultation

Case 1

Jane was a 16-year-old girl with a history of depression, deliberate self-harm and possible sexual abuse. She had previously been an in-patient at the local adolescent psychiatry unit, where attachment issues and a poor relationship with her mother were identified, and following discharge she was followed up by the local CAMHS team. She was also on a supervision order and would have been accommodated, but owing to a lack of suitable resources she continued to live with her mother. Jane was poorly compliant with her antidepressant medication, sitting around at home and smoking cannabis. Her social worker attended for consultation, wondering if there was anything he could do to encourage Jane to take her medication. It was obvious from discussion that he had a good relationship with Jane and motivational interviewing was suggested as an approach that might help. A brief explanation was given and material was subsequently sent to him to help provide orientation to this approach. Aware that the local CAMHS team were already directly involved, the specialist registrar also suggested it might be helpful for the social worker to liaise with Jane's mental health worker and possibly even to accompany Jane to her next appointment if she is agreeable to this.

Case 2

A 7-year-old boy, Colin, had been involved in a near-fatal road traffic accident 12 months earlier. He suffered significant abdominal injuries but made a good recovery.

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Previously giving no cause for concern, Colin's behaviour since the accident had deteriorated both at home and at school and he was in danger of being excluded from the latter. He was aggressive and disruptive to other children and his mother was finding it increasingly difficult to cope. The social worker was unsure how best to proceed, indicating that various behavioural strategies had proved ineffective so far. After further discussion, it was thought this would be an appropriate case for referral to the local CAMHS team, for assessment and consideration of a possible diagnosis of post-traumatic stress disorder.

Case 3

Josh was a 5-year-old boy displaying difficult behaviour with his mother, calling her names and not doing as asked. He was the youngest of three boys by three different partners and his mother was on a methadone maintenance programme. During observation by the social worker, the mother and her partner were noted to be very rejecting of Josh, giving him only negative attention and never praising him for things he was doing well. At consultation, there were insufficient concerns to raise child protection issues and his social worker was wondering about doing some parenting work with the family. It was agreed that this would be helpful and the possibility of attachment issues was highlighted, including consideration as to how this might be worked with.

Conclusions

Given that consultation with primary care agencies is increasingly becoming an important role for CAMHS teams, opportunities should be developed to give trainees increased exposure to this approach. While this consultation service has continued to adapt and evolve in response to the individual needs and aspirations of trainees and social workers, the specialist registrars who have taken up this opportunity have all found it invaluable in preparing them to become true 'consultants' in child and adolescent psychiatry.

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Declaration of interest

None.

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