special articles

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Child and adolescent mental health services liaison with Tier 1 services

A consultation exercise with school nurses

Consultation with Tier 1 professionals is an integral part of comprehensive child and adolescent mental health services (CAMHS) (NHS Health Advisory Service, 1995; Audit Commission, 1999). Despite enthusiasm for consultative approaches and clearly described advantages (Steinberg, 1993), the evidence base for consultation work is thin. In schools, the consultation intervention has been found to be the least effective of four interventions (Kolvin *et al*, 1981). Consultation enables the development of an integrated tiered system, improves communication, provides a greater understanding of the roles of CAMHS by Tier 1 professionals and fosters more relevant referral patterns.

Focusing consultation work on the concerns of the consultees and measuring their change in relation to those concerns is proposed as a realistic method of evaluating consultation. School nurses often find themselves presented with pupils' emotional and psychological difficulties. Schools look to their nurses for support and information when a pupil has had contact with mental health services or has behaved in a worrying manner. School nurses can lack confidence in these areas of work as they and their professional supervisors have little or no mental health training. Consultation to school nurses offers a forum for addressing this lack of confidence.

Aims of the consultation

The aims of the consultation, agreed with the consultees, were to:

(a) improve communications channels between CAMHS staff and the school nurses;
(b) develop guidelines for CAMHS liaison with schools;
(c) develop guidelines for managing young people after overdoses;
(d) develop guidelines for dealing with self-referrals to school nurses;
(e) develop guidelines for setting time limits;
(f) develop guidelines for making appropriate referrals to CAMHS;
(g) understand the functional structure of CAMHS;
(h) clarify referral routes;
(i) learn how to understand and set boundaries;
(j) discuss issues around the mental health of young people;
(k) discuss young people referred to the school nurses;
(l) learn how to manage young mothers and their behaviourally disordered children;
(m) learn how to manage anxiety in ourselves and in the schools;
(n) learn how to deal with bullying;
(o) learn how to prioritise.

The authors also investigated how the school nurses felt about differing aspects of their work in order to get a sense of their working and personal approach to their professional task.

Organising the consultation

From the information elicited in the first session, an analogue rating scale, which highlighted the issues raised by the nurses in the first session, was developed as an evaluation questionnaire. At the beginning of each meeting an agenda was set to include items brought by school nurses as well as items on which the school nurses had requested more information from CAMHS. These items were recorded so it was possible to look back at what topics had been covered during the study period.

The consultation process

The consultation process began in June 1996 and has operated on a monthly basis in term time subsequently. The sessions offer opportunities for specific case discussion, discussion of professional issues (for example, the role of CAMHS, boundary setting, role definition) as well as a forum for more formal teaching on clinical areas of interest and relevance to the school nurse task (e.g. deliberate self-harm, attention–deficit disorder, eating disorders) as well as issues of clinical management (e.g.

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working with difficult parents, managing school teachers' anxieties). The school nurses can also phone to discuss issues and seek advice and support between the sessions.

Comments

From the questionnaires used after 6 months' consultation, it was clear that knowledge had been acquired about the functioning of CAMHS and some confidence had been gained by nurses in managing young people who take overdoses and suffer from mental health problems. In general, these were felt to be more within the nurses' capability. Nurses felt less threatened by parents. There was a decreasing feeling of being valued by the employing trust and of being paid appropriately for the job. The questionnaires revealed that, after 42 months, these changes had been consolidated.

Clearly, not all changes in school nursing practice and beliefs can be put down to monthly consultation sessions. However, understanding the school nurses' preoccupations helped focus the consultation. There appears to have been an improvement in school nurses' understanding of the functioning of CAMHS and with certain nurses of how CAMHS work with schools. Confidence in managing young people after they have taken overdoses and those suffering from other mental health problems has been consolidated.

The conclusions of any evaluation with small numbers must be regarded as impressionistic. However, this work has demonstrated that consultation can be evaluated using analogue questionnaires based on information given by consultees on their work. Such a method has the advantage of working with an agenda that is developed by the consultees who feel involved in the process. Consultation time can be devoted to areas where change would be most desirable. An incidental by-product is that we now accept referrals from school nurses who are very good at discussion regarding appropriateness prior to referral.

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Cubiculum squalidum (ICD–10: F91.9)

All adolescent psychiatrists will know untidy bedrooms to be part of the day-to-day currency of parent–child frustration. Is it too universal to achieve caseness and a place in ICD–11? Nowadays, when an adolescent is described as having a tidy bedroom, my mind starts reviewing their other symptoms to check for a developmental disorder. Universality has not, however, generated many helpful therapy strategies in psychiatric textbooks.

Very reasonably, behaviourists see this as a statement of individuality, and separation of the adolescent's will from that of his or her family. Family therapists would perhaps insist the process was more dynamic and involved active protest motivated by a need for autonomy. Developmentalists would propose this as another phase in identity differentiation and formation. Psychotherapists might interpret the untidiness as emotional chaos unleashed by the struggle with separation from the parent. The jobbing child and adolescent psychiatrist simply wants a strategy to take the heat out of family conflict.

Some years ago I was working with a barrister's family where the problem was "the hostile attitude of our daughter". I struggled to engage this barrister, he clearly perceived me as hopelessly vague and pragmatic. Had he not presented his case with irrefutable evidence? Was the case not proven? Meanwhile his daughter was conveying her exasperation by every non-verbal means available; the mother trying to mediate (as was her habitual role). A judicial ruling was clearly being sought.

The 'contract' that follows was in lieu of that ruling. I have used this contract often as a means to get families debating the real issues behind the complaint of untidy bedrooms. I am sure the problem has been exacerbated by the great efforts some parents make to furnish children's bedrooms nowadays, and the cost of the clothes and CDs that cover the floor. Only the original barrister attempted to get the contract signed, most parents simply have fun with their teenagers trying to fit their complaints into the framework provided. Hopefully disequilibrium generates an opening for change.

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