A Brief Consultation and Advisory Approach for Use in Child and Adolescent Mental Health Services: A Pilot Study

SAM HEYWOOD
North Staffordshire NHS Trust, UK

JOHN STANCOMBE
Trafford Healthcare NHWS Trust, UK

EDDY STREET
South Wales, UK

HELLE MITTLER
?

CAROL DUNN
Stockport CAMHS, UK

LEO KROLL
Royal Manchester Children's Hospital, UK

ABSTRACT

In England, the demand for, and access to Child and Adolescent Mental Health Services (CAMHS) have led to endemic and intractable problems: long waiting lists, non-attendance and complaints of inaccessibility from both users and referrers. The dilemma facing CAMHS is how best to respond to rising demand without compromising the quality of specialist secondary care services. As a pilot, we developed an alternative model of service delivery that provided a brief (2+1) consultation. We also created a manual as a guide to this process. This was evaluated with 50 families, who were seen within four weeks of their returned questionnaire. Strengths and Difficulties Questionnaire (SDQ) scores showed that 72% of families improved and 95% of parents were satisfied with the service they received. This approach is brief and empowering, and is sufficient to produce change. Implications for services using this approach would include: (i) informing referrers of the alternative model, (ii) training requirements, (iii) increasing the number of mental health workers so that secondary care services are able to function effectively, and (iv) allowing more specialist services to deal with the more severely disturbed cases.

KEYWORDS
CAMHS, client-centred, consultation, parental expectations, two-plus-one-model (2+1)
Background

Pilot projects in adult mental health services (Jones, Moss, & Holtom, 1997) suggest that brief intervention of a consultative, advice-giving nature, augmented by self-help materials, can be an effective strategy in reducing waiting lists and obtaining high satisfaction ratings from users. Street and Downey (1996) have developed a brief consultation approach to work with children and families, and report positive comparisons with traditional approaches (Street, personal communication). However, this model of service delivery has not been subjected to any formal, systematic evaluation.

Non-attendance rates to first appointments of 20–35% are not unusual in CAMHS (Audit Commission, 1999). Research on the user-perspective suggests there is a ‘lack of fit’ between user-expectations of CAMHS and what traditional services routinely provide (Mason, Watts, & Hewison, 1995; Reimers & Treacher, 1995). Parents do, however, expect the contact to be brief (Wheeler, 2000), and recent studies (Hoare, CLINICAL CHILD PSYCHOLOGY AND PSYCHIATRY 8(4) 504

Acknowledgements: The research team would like to thank North West R&D for funding the project, the families who took part, the CAMH team in Stockport, Frank Baylis and Debbie McDonald for typing the transcripts, and Sally Despenser for her diligent proof-reading.

Sam Heywood is a Counselling Psychologist currently working for North Staffordshire NHS Trust in a Sure Start project. Prior to this she worked in Stockport CAMHS for 6 years, with particular interests in problems with eating and self-harm in adolescents. Her research interests have been in brief consultation and qualitative aspects of therapists within the NHS in terms of service delivery.

John Stancombe is a full-time Consultant Clinical Psychologist in the NHS with over 20 years experience of practice. He currently works in the Child Psychological Service of the Trafford Healthcare NHS Trust in Manchester. He has recently completed discourse analytic, doctoral research on family therapy process, which explores the rhetorical-moral dimensions of therapeutic practice.

Eddy Street is a Chartered Counselling and Clinical Psychologist working for the NHS in South Wales. He has a special interest in working with families that are dealing with handicapping conditions and the effects of trauma and abuse.

Helle Mittle is an independent researcher with an extensive background in social work.

Carol Dunn is a Staff Grade Psychiatrist working in Stockport CAMHS with an interest in psychodynamic and family therapies.

Leo Kroll has worked in Manchester for the last 10 years, the last 6 being as a Consultant Child and Adolescent Psychiatrist. His current post is working in an out-patient team within a deprived inner-city environment. He has research interests in needs methodology and its application in real clinical environments. He is currently part of a number of research teams using needs assessment with different groups of children and adolescents. He also has interests in children and adolescents who have hearing problems, brief consultation and treatment approaches, and the use of the Internet to reach adolescents who do not access traditional NHS services.

Contact:
Norton, Chisholm, & Parry-Jones, 1996; Stallard & Sayers, 1998) show that the majority of families referred to CAMHS are seen fewer than three times.

**Difference between consultation and ‘traditional’ approaches to assessment**

‘Traditional’ assessments gather information and usually lead to a diagnosis, formulation and treatment plan. Whether the opinions of the professionals match the expectations of the family may be critical in determining what happens during the first few sessions. The way professionals approach assessment can determine a dynamic outcome such as whether parents want to return or not (Wolpert, 2000). In consultation, however, the family are given the opportunity to talk about their problem from their own perspective. Rather than imposing an assessment based on theory and professional practices, the consultative approach first uses a more parent-centred stance; the justification being that this leads to a better understanding between assessor and the family regarding different perspectives on need. This approach allows clear articulation of the expectations the assessor has of the family and the family has of the assessor and CAMHS service, leading to greater collaboration and neutrality between the consultant and family in the assessment. This enables the family to make their own informed decision about whether to engage in therapy or take an alternative course of action (Street, personal communication).

**Consultation: Definition and scope**

In essence, the model developed is a brief, collaborative, client (parent)-centred way of working with families. The two plus one approach is based on Barkham and Shapiro’s (1989) 2+1 model in adult psychotherapy services, as well as Street and Downey’s work (1996). The consultation process is organized around four key areas (Street & Downey, 1996):

- establishing an interactive view of the referral process;
- learning about how the family understands their problem(s);
- eliciting how the family view the process of consultation, their notion of therapy and treatment;
- determining and negotiating with the family what needs to be done to meet the family’s expectations and needs.

Two initial sessions focus on parental views of the problem(s), concentrating on their perceptions of causation, referral and expectations. The consultation stresses the need to build an alliance with parents. Although the approach is not directed explicitly at change, it may act as a catalyst for change. Parents should feel that they can do something to help themselves or their child, or at least cope better, as a result of the consultation. Acting in the role of consultant, rather than therapist, the CAMH professional does not assume that involvement will develop into a therapeutic relationship or that the family need on-going therapy.

**Aims of the study**

1. To develop a manualized package based on Street and Downey’s (1996) model. The intention was that the package should: (i) be brief, (ii) be user-friendly, (iii) be alternative to traditional assessment, and (iv) include practical advice.
2. To pilot the package with families in an outpatient setting and evaluate its use.
Method

Stockport CAMHS is located in a mainly urban, mixed deprivation area, with a population of approximately 300,000. The majority of people referred to the service classified themselves as Caucasian. Exclusion criteria for the study were complex and chronic problems, requests for medication for attention deficit disorder, overdose or self-harm referrals, families actively involved with Social Services, and requests for psychiatric assessment (e.g. severe depression, psychoses, eating disorders, moderate to severe learning difficulties). Ethical approval for the study was granted.

Developing the manual

Process of manualization We developed a proforma for use in consultation sessions. The proforma is given within the appendix of the manual (Heywood Kroll, Stancombe, Dunn, & Street, 2001) and was unchanged (apart from layout) throughout the study. The manual was written and modified via feedback from families and with consultation from ES (Street, personal communication). Clinical vignettes were included from our experiences of offering consultation sessions.

Evaluating the model

Questionnaires used An opt-in questionnaire was completed by parents. It collects basic information, including details of the presenting problem, involvement (previous and current) of other services and parental expectations.

Engagement questionnaires used in an in-patient study (Kroll & Green, 1997) were adapted for use in this study. The version for adolescents and parents consists of seven sub-scales with nine boxes ranging from positive to negative. The child’s version has six sub-scales with pictures depicting scores from 1 to 4.

The Satisfaction and Effectiveness Questionnaire was adapted from an in-patient study (Green et al., 2001). It consists of seven sub-scales rated from 0 to 3 and is completed by parents and adolescents. Three of the questions are based on Howie et al.’s (1999) work in GP consultations.

Design This open pilot study recruited 50 cases, there was no control group. Measures were taken at five time points.

Time 0: Referral point Following referral, the parent(s) were sent an opt-in questionnaire and the parental SDQ (Goodman, 1997).

Time 1: First session This was within four weeks of returning the opt-in questionnaire. A parental and school SDQ was obtained. The clinician completed case complexity scores (Pearce, 1994) and the Children’s Global Assessment Scale (CGAS; Shaffer et al., 1983).

Time 2: Second session (2 weeks later) At the end of the second session, the parents, children and young people completed the engagement questionnaire. The consultant recorded the CGAS.
Time 3: Third session
This was approximately 2 months later. Parents and school completed the SDQ and the satisfaction questionnaire. Parents who did not attend were sent questionnaires by post. The clinician completed the CGAS.

Time 4: Follow-up
Eleven families (randomly selected) were seen six months later and interviewed by an independent researcher (HM). The audio-taped semi-structured interview focused on four main areas.

1. How acceptable the service was and whether it met the families' expectations.
2. How families used the information offered in the sessions.
3. Whether the consultation helped them change the way they thought.
4. Whether there were any other events that had made a difference to the problem(s).

Process of consultation  Two psychologists (SH and JS) and the staff grade psychiatrist (CD) saw families for two consultation sessions approximately two weeks apart, with a follow-up two or three months later. Generally, the whole family would be invited to the first session, with the option for them to decide who should attend the second.

Data analysis  We used a combination of quantitative and qualitative methods. For the quantitative analysis, SPSS (version 9) was used to describe the data and to perform paired t-tests. Qualitative analysis included transcribing a selection of cases for analysis and also for use as anonymized ‘live’ examples for the manual. Eight of the 11 six-month interviews were transcribed, analysed thematically and categorized (Kvale, 1996). One family refused to be recorded and the equipment did not work properly in the other two interviews.

Treatment integrity  A third of the consultation tapes were randomly selected and rated for reliability by the research team. Treatment integrity was high (over 95% compliance with the manual).

Results

Outcome: Quantitative analysis

Sample characteristics  The children ranged in age from 5 to 16 years, average age was 10.3. Twenty-two (44%) of the children were aged over 11, 33 (66%) were male. Most referrals were for behaviour problems. At the initial appointment, case complexity scores ranged from 2 to 19 with a mean of 9.4 and CGAS scores ranged from 40 to 85 with a mean of 56.6.

Comparison with routine referrals  We compared means for SDQ, case complexity and CGAS scores between the research group and routine referrals to CAMHS. This showed that there was little difference between them, as detailed in Table 1, apart from case complexity, which should be lower given the exclusion criteria.

Figure 1 illustrates the pathway for the 50 families selected. Three families did not attend the first appointment so the total number of families seen was 47. Of these, 25 families had a total of three consultations; those having fewer were either referred on at this stage or they opted out. Twelve (24%) were placed on the CAMHS waiting list for
further therapeutic work and the remaining 38 (76%) were discharged. Thirty-five of the 47 received advice or an opinion from the consultant and 26 received written information.

Table 2 shows the changes in mean scores for CGAS, parental and school SDQ scores using paired t-test analysis. This illustrates improvement in overall functioning: there was
a decrease in total parental SDQ scores between the first and final consultations, indicating that symptoms were reduced, and there was an increase in CGAS scores.

Table 3 shows a breakdown of the SDQ scores into pathology subscales after using paired t-test analysis. This reveals significant changes in conduct and emotional problems, as reported by parents.

**Engagement and parental satisfaction**

The engagement questionnaire was completed by 36 (72%) of the parents, 12 (55%) of the adolescents and 13 (46%) of the children. Forty-one (82%) parents and 11 (50%) adolescents completed the satisfaction questionnaire.

**Parent engagement**

Of the 36 (72%) parents who completed the questionnaire, 33 (92%) felt able to be open and honest with the consultant. Twenty-nine (81%) felt the consultant had the ability to help them overcome their problems. Twenty-five (71%) thought the treatment offered was going to change the things they wanted to change and 26 (74%) thought the treatment would benefit.

**Adolescent engagement**

Only 12 of 22 teenagers completed the questionnaire. Of these, 7 (58%) felt the consultant had the ability to help them overcome their problems, 5
(42%) thought the treatment offered was going to change the things they wanted to change and 6 (50%) thought the treatment would benefit in the long-term.

**Child engagement**  Thirteen of 28 children completed the questionnaire. Of these, all 13 (100%) reported that they felt able to tell the consultant about themselves. Twelve (93%) thought that the consultant understood the family’s problems, and all 13 (100%) thought that coming to see the consultant would make things better for the family.

**Parental satisfaction**  Forty-one parents completed the satisfaction questionnaire, 39 (95%) were satisfied overall with the consultation and advice model. All 41 (100%) thought they had been listened to and understood, 38 (93%) were satisfied with information and advice given and 32 (78%) felt better able to cope with the problem.

**Adolescent satisfaction**  Eleven of 22 completed the questionnaire. All 11 (100%) adolescents were satisfied overall with the consultation and advice model, thought they had been understood and were satisfied with information and advice given. Nine (82%) felt better able to cope with the problem.

**Outcome: Qualitative analysis**
The main themes identified with the 11 families who were interviewed at six months, fell into four categories.

1. **Positives of the consultation and advice model**  Many parents were glad they did not have to wait for an appointment. Others thought the most helpful thing was having ‘an outsider’ to talk to, often for the first time.

   Young people said that they felt understood, listened to and didn’t feel criticized. One adolescent recalled, ‘Instead of telling me what to do, they told me I could sort it out myself, so I told myself what to do in the end’.

2. **Changes in perceptions and actions**  One parent talked of her surprise at hearing ‘at how articulate he (her son) was’ and she ‘learned how deeply he felt’ as a result. Another parent stated: ‘I think I was over-compensating for a situation I had no control over. Now I say, “that’s how it is” ’. Some parents described an increase in confidence in their parenting style, for instance, ‘It made me handle things better’ and ‘He (son) can still test me but I can deal with it now’.

   Young people talked of feeling ‘happier’ about themselves and that having the consultation ‘helped me understand how I was feeling’. One child said, ‘I was hoping that mummy could understand, I think she understands me more now’. Another young person described how it helped him manage his anger because ‘Before I used to look at myself from the inside but after I went, I seemed to be looking at myself through a glass ball, from the outside’.

3. **Impact on the family**  Parents talked of feeling ‘less stressed’ because there is less arguing or shouting, and feeling ‘a lot closer’ as a family.

4. **Issues and suggestions**  Most of the feedback concerned the focus and length of the sessions. They gave some suggestions of how to improve the service, such as wanting ‘more explanation’ before the consultation and more ‘exploration’ or ‘evaluation’. A number of families wanted more sessions. None of them regretted entering into the pilot study.
Discourse

Outcome of the study
This pilot study has shown that for the majority of the 47 families seen with non-complex problems, a brief consultation and advice model was sufficient to produce change. This is most likely to be because of changes in parental thinking and attitude towards the child’s problem. Advice, self-help literature, alongside the fact that parents were listened to, felt understood, and were able to discuss their concerns, seemed important in facilitating attitudinal change. However, for some families, giving a specific diagnosis was import.

Impact on consultants
The impact of this model on the consultants was mixed. First, all the consultants found that using this model altered their style of assessment, and made them more reflective about their work. Second, it felt liberating to see families for a set number of sessions, but staying within the three sessions framework felt constricting for some families. Finally, focusing only on the primary presenting problem was sometimes difficult, as other problems often emerged whilst families talked. It was often a challenge to manage other issues sensitively and yet remain focused on the primary problem.

Implications for services
Services who wish to set up a brief consultation service would need to consider the relationship between length of their waiting list, and their views on evidence based practice. Our study suggests that brief interventions can be effective, as judged by the parents. A longer follow up period would be required to see if this effect is sustained.

Services would also need to consider how best to develop a 2+1 as a method of triage (Stallard & Sayers, 1998). Our view is that using questionnaires or referral letters is an inaccurate and potentially risky way of trying to prioritize referrals onto a waiting list. Our study would support Stallard and Sayers (1998) view of brief assessments as a first step, and referral onto a secondary waiting list if necessary.

Further implications of using this model include: (i) informing referrers in primary care of the alternative model, (ii) training CAMH professionals, and (iii) making sure that tier 3 services are available to deal with more complex and chronic cases.

Limitations and conclusions
There are a number of clear limitations. First, the study is a pilot and numbers were relatively small so it is difficult to generalize these results to other CAMH services. Second, we selected certain cases, including those with a clear perceived need for a psychiatric assessment. Third, enthusiastic researchers conducted the consultations, with perhaps an invested interest in wanting consultation to work. Fourth, although parents reported high degrees of satisfaction on their questionnaires, it is possible that such scores were biased. Despite our attempts to collect a complete set of data, some families would not return postal questionnaires. Finally, we do not know whether the families seen for consultation return with recurrent problems.

It would be useful to see whether this approach works in other CAMHS, ideally comparing outcomes of this approach with a more traditional assessment.

References
CLINICAL CHILD PSYCHOLOGY AND PSYCHIATRY 8(4)


