# Understanding child mental health consultation from the perspective of primary health care professionals

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## Abstract

**Aim** To explore the understanding of mental health consultation and its utilisation from the perspective of primary care workers working with children and young people who experience mental health issues.

**Background** Recognition of mental health consultation is respected and advocated as a way forward to support those professionals who may not necessarily have the training or understanding of child mental health issues, yet come across them frequently as part of their daily practice. Little is known, however, about how primary care professionals understand or utilise mental health consultation.

**Design** A qualitative research design informed by phenomenology.

Methods: School nurses (n=6) were purposively sampled. Semi-structured interviews were undertaken, facilitated by the use of open-ended questions. All interviews were audio-recorded and transcribed, followed by vigorous thematic analysis.

**Results** Five overarching themes were identified from the data. These included: communication; crisis identification; hindrances; resources; and expectations. Each main theme consisted of several sub-themes relating to issues of professional identity; blurring of professional boundaries; constraints such as time management and workload; and the participant's own needs, including self-confidence and educational needs.

**Conclusions and implications for clinical practice** When utilised, mental health consultation proved effective in supporting the participants to address the mental health needs of children and young people; however, there are several factors such as lack of resources, differing perceptions of mental health consultation and personal challenges that prevent full engagement. This research contributes to existing knowledge by advocating that all individuals participating in mental health consultation should be encouraged to embrace the practice and understand what it actually means within the context of their own discipline.

**Keywords** Child, consultation, mental health, phenomenology, primary care, support.

**What is known about this topic**

- The importance of mental health consultation has become widely accepted in Australia, particularly within adult emergency departments. One could argue, however, that this is not the case in children's services, with mental health consultation still used on an ad hoc basis by primary care professionals. Factors that influence this may be that primary care workers do not understand what mental health consultation is or how it can be utilised in their work. Furthermore, the literature to date on mental health consultation appears to devote attention to the process and theory of consultation rather than describing the dynamics and perceptions from those using it. Thus, it is believed that a lack of literature on mental health consultation for primary care workers working with children and young people indicated the current understanding in the area is incomplete.

**What this paper adds**

- The findings have highlighted that, despite the general agreement between professionals working with children experiencing mental health issues that mental health consultation is needed, it appears difficult to put into practice in a consistent manner due to the different perceptions people have of it and how it can be used in the first instance. Though it is not within the scope of this research to stipulate a model of consultation, it has highlighted that individual, organisational and external system-level factors all contribute to the success of mental health consultation.

## Declarations

**Conflict of interest** None

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**Ethics** Flinders University Social and Behavioural Ethics Committee

**Contributions** Concept of study DO, data collection DO, written by DO and edited by PB and EMC.

## Background

The last decade has seen an increasing focus on child mental health worldwide with Australia clearly calling for those working with children and young people to take more notice of a child or young person's mental health needs[1]. In Australia, as internationally, figures reveal 14–20% of children and young people experience mental health problems that in turn creates more demand for professionals to act in response to these needs[2]. Strategies such as prevention, promotion and early identification provide a perfect vehicle to address the issue and inevitably lead to better health outcomes later on in life[3-7]. This, however, demands far greater coordination and cooperation within an interagency framework[1] than seen previously and is often dependent on the level of training, support and consultation a professional receives if it is to be effective[8].

The paucity of resources, fragmentation of services and lack of available professionals specifically trained in the area of child and adolescent mental health cannot meet the high demand of services required, thus waiting lists are often the norm of community services[9]. One way to address these issues and support the needs of children and young people is the commitment to multi-agency working relationships, both from the specialist Child and Adolescent Mental Health Services (CAMHS) professionals and other agencies, particularly in primary health care. One example of this is to promote the use of mental health consultation. Mental health consultation involves those who have specialist knowledge and skills in child mental health to offer regular consultation to those primary health workers who are struggling with the demands of the child and family and often feel ill equipped to manage the issues[1,9,10].

The concept of mental health consultation is not new. Since Gerard Caplan's seminal work from the 1960s[11] it has gained considerable popularity, as has the nature and definition of its adaptation to suit certain contexts and the different professional groups using it. Despite various guises, recognition of the influence of mental health consultation and importance in service delivery is respected and advocated as a way forward to support the increasing mental health issues being experienced in today's society[12]. Offering a logical approach mental health consultation helps to support those professionals who may not necessarily have the training or understanding of mental health issues yet come across them frequently as part of their daily practice. Such professionals including paediatric nurses, child and family health workers, social workers, and teachers who are in key positions to recognise problems at their onset and implement strategies to alleviate them at an early stage with support from specialist child and adolescent professionals via the process of mental health consultation.

Caplan's original model of mental health consultation was used broadly as a working model for the purpose of this research, despite some literature stating a "fresh look" is required[13]. However, a literature search provided very little in terms of evidence or description of evolving models in the area of CAMHS, whereas Caplan's model was clearly visible in the literature over decades as providing a strong influence shaping consultation practice[11,14-17].

Caplan's model[18] is based on four different types of consultation, namely: Client Centered Case; Consultee Centered Case Consultation; Program Centered and Administrative Consultation. With policy driving professionals to incorporate health prevention, education and early intervention as strategies to meet the unmet needs of young people and their families experiencing mental health problems, client-centred case consultation was utilised to define mental health consultation for the purpose of the research.

According to Caplan[17], client-centred mental health consultation involves two or more participants with one of the participants (consultant) offering a sound knowledge base to empower and support the other participant(s) (consultee) to work with a client they have responsibility for, in this case a child, young person or family. Shared problem solving, an equal partnership and the opportunity to remediate and/or prevent a mental health problem become the core components to the process, though in the last few years there has been dispute over whether Caplan's model is in fact advocating for the consultant (expert) to work with the case *through* the consultee (non-expert) rather than supporting and enabling the consultee to work within their own context of practice[19].

The consultee profits from the relationship in such a way that future problems may be responded to more effectively and handled with more confidence and skill. The consultant or the service they represent profits from the relationship via the opportunity to implement early interventions, thereby reducing referrals in the long term[12]. This inadvertently also releases CAMHS staff to work with those clients deemed to have mental health problems more serious in nature and can in fact speed up access to specialist services if necessary[12].

Mental health consultation liaison services in emergency departments has evolved with consultation-liaison nursing roles, specifically developed to support other non-mental health professionals in managing mental health problems in their department[20-22]. Yet, mental health consultation in CAMHS is not taken up as much as one would hope or presume[23]. One possible reason for this could be that though the importance of consultation may be widely accepted, the

lack of a clear definition, or a framework for implementation, and poor understanding of factors that may impact on its development are still little understood in the child adolescent context. Furthermore, the majority of publications relating to mental health consultation appear to concentrate on the process and theory aspect of it rather than describing the practical elements such as the dynamics and perceptions of it from a professional's perspective.

## Methodology

### Design

The research methodology was informed by interpretive phenomenology. Exploring the lived experience of a lived or social phenomenon and revealing the meaning behind it suited the aims of the research to explore the understanding of the phenomenon – mental health consultation and its utilisation from the perspective of primary care workers[24-25]. Participants reflected on the mental health consultation they received in their professional practice in order to explore how it was interpreted, defined and described.

Semi-structured interviews, which included open-ended questions were conducted with six professionals who managed a significant number of children or young people with mental health issues in their daily practice, yet had little or no training in mental health. The participants were purposively sampled from nurses working within a school environment, based on international literature recommending schools as being ideally placed to recognise and support mental health issues[26-28].

### Data collection and analysis

Interviews varied from 45 to 60 minutes They were audio-recorded, transcribed and analysed to discover the meaning of mental health consultation for those nurses working within a school environment.

Data collated provided a rich and detailed account of how the participants understood mental health consultation in the context of their own practice. Despite the complexity of the data, following vigorous thematic analysis using Burnard's[29] stage-by-stage process, various connections or clusters emerged. These clusters were condensed and refined into five major themes with underlying sub-themes. In the process of consolidating the findings and beginning the process of analysis, links and tenuous connections further emerged, intertwining some of the sub-themes; therefore, the themes cannot be fully grasped in isolation but must be viewed and understood within the context of the whole phenomena.

Ethical approval was obtained from the University's Social and Behavioural Ethics Committee and safety of the data and other ethical issues such as anonymity/confidentiality, informed consent, maintenance of dignity and benefit to risk ratio, were addressed accordingly within the study[30-31].

## Results

Five overarching themes and several sub-themes were identified from the data. These included: communication; crisis identification; hindrances; resources; and expectations (Table 1).

### Theme: Communication (Box 1)

Findings indicated there was a major gap in communication between the service requiring consultation and the service offering consultation. The participants wished to ensure communication was clear and open between the consultee (themselves) and the consultant. However, they felt that at times some information was not filtering through to them and, therefore, inhibited collaborative practice. Feelings of frustration due to misunderstanding and miscommunication based on people's expectations and understanding of the consultation process were common and resulted in negative experiences for the participants. Similarly, ignorance and lack of understanding or respect for each other's roles, skills and unique competencies complicated the communication process further, leaving some participants unwilling to maintain a working relationship. When a consultative relationship was established, it was a priority for the participants to not only set and plan goals but to clarify each other's role in planning care. This provided something tangible that could be used in practice; however, false expectations of each other and different agendas left some feeling there was an expectation for them to take on more work than they were able to.

*Table 1. Results of thematic analysis – themes and subthemes.*

| Communication | Crisis identification | Hindrances | Resources | Expectations |
|---|---|---|---|---|
| Working relationships/ collaborative practice | Risk assessment/ crisis identification | Time constraints and workload of school nurses | The need for practical solutions | Advice, support and encouragement |
| Working towards the same goals (goal setting) | Risk taking/clinical judgement | CAMHS waiting lists | Training/ education | Expertise/knowledge |
| Role clarity | Containment/ managing a case | Professional identity and role conflict (fear of role expansion) | | Offloading baggage/supervision |
| | | Responsibility of the problem | | Increase in confidence |

*Box 1*

*"We should be working together, sorting things out as a team, with both sides having an equal voice but the reality is that we're not that good at it."*

*"We are all on different sides of the fence. CAMHS, me, the teachers, the social services. We all have our own agenda even though we say we want what's best for the child. We do, but only if it means we don't have to do any extra work. So we nod at each other and look like we have an agreed plan of action but then go and do what fits in best with our role. It's lip service "*

*"We all hopefully are working towards the same goals. It's just difficult if I don't understand what the other goal is or what people are talking about. People forget school nurses don't have any mental health training and yet because we're in the midst of it on a day-to-day basis it's presumed we know all about it."*

## Theme: Crisis identification (Box 2)

Participants described feeling completely out of their depth, both in knowledge and experience when faced with mental health issues. A fear of a wrong word or a wrong action triggering an unwanted behaviour was often cited. Other feelings of not being able to contain the situation, it getting "out of control", and feeling "helpless" were common phrases used, causing distress in both the workplace and home life for some participants.

Mental health consultation was seen as an avenue to remove this stress or contain the case (usually identified as young people exhibiting suicidal or self-harming behaviour) to a level they felt comfortable with via direct action from the CAMHS team, yet one participant was genuinely surprised that CAMHS did not appear as concerned about a specific case as she was. On the other hand, one participant actively used mental health consultation, but described the resulting stress of implementing a technique she was uneasy with, and the fear of reprisal if it had not been successful, was too great for her to contemplate doing it again.

Education and, in particular, risk assessment tools were identified as useful in terms of knowing when to refer further but most made it evident that the pressure they endured on a daily basis was well beyond their role and didn't want this complicated further by having to do risk management. Risk management, therefore, was perceived as something that CAMHS should undertake.

*Box 2*

*"It's hard sometimes. You know like when I'm desperately concerned about somebody but I never know if that's me or whether I should contact somebody. Sometimes what I think is a real, real biggy, you know like, somebody saying they're going to kill themselves, CAMHS don't seem that concerned and I wonder why."*

*"It's very scary sometimes to know what to do or what to say. I had a young girl last year. She kept wanting to see me but then would never turn up at the agreed time. She used to turn up without fail just as I'd be leaving and, well, well, I'd end up dropping everything else to see her. You know, I was always concerned she would kill herself. I was discussing it in consultation and got told that I should stick to boundaries. Something about therapeutic boundaries. I did and it worked – she turned up on time the next time but what if she hadn't? What then? Don't think I can go through that again. The stress."*

*"When a family has a crisis, we're the ones holding it in the interim cos of the year's waiting list or whatever and it's very, very difficult for us to deal with."*

## Theme: Hindrances (Box 3)

"Hindrances" refer to identified obstacles to be overcome in order to access and maintain regular consultation. Evident in the findings were practical resource issues such as time constraints (workload), funding, and location, all of which had a profound influence on the attendance rate of participants.

Participants acknowledged their workload felt too overwhelming to spend time on something that they didn't fully understand and where they were uncertain about how it would benefit them. There was a clear directive that unless the consultant had a "quick-fix" that would ultimately help them out, for example, helping their client to be seen immediately or not be placed on a waiting list, then mental health consultation was an unnecessary aspect in their valuable time.

Of interest was that what first appeared to be a hindrance to implementing consultation can also be argued by those who actively engaged in consultation as an advantage. Not dismissing the fact of time constraints and busy workloads for participants, the participants who actively engaged in consultation found the process of consultation enabled them to manage their time more successfully. One participant reported that, prior to consultation, incidents where she had initially spent many hours reflecting on the best course of action, once given the opportunity to discuss it, she felt more able to deal with future problems efficiently and effectively

in a timely manner, freeing her up to participate in other activities. In a similar vein, two of the participants believed consultation was an invaluable support mechanism whilst their client was on the waiting list.

*Box 3*

*"Time is always a problem. We all have really heavy workloads, are overstretched and they want us to attend a meeting that may or may not be useful to us. I don't think so."*

*"What's the point in going? I went once and came away with more work to do when all I wanted was to maybe move the kid further up the waiting list. The only advice I got was suggestions on how to work more with him; that's more of my time."*

*"I've been doing this job for eight years and it's not what I signed up for. I'm a school nurse not a bloody psychologist."*

### Theme: Resources (Box 4)

Most participants expressed a desire to develop a repertoire of resources they could use in practice. Education to extend their knowledge, either through formal or informal training, was perceived a priority. Within this, some spoke of requiring practical tools they can use in daily practice rather than in-depth knowledge about specific mental illness. One significant finding suggested group mental health consultation as far more advantageous than individual consultation as it provided the opportunity to listen and learn from other's case discussions.

*Box 4*

*"A few more lectures and training sessions would be great, but sometimes I just go to the meetings cos just chatting about different things and listening to others helps"*

*"I'm just thinking of one most recent one we had last month. There was a practical teaching about assessment. If it's an eating disorder or anything else, you know, to make sure we're asking the right questions, to know what to look for cos obviously we're not mental health trained and could miss out things. We did a checklist of key questions to ask really. Which was really useful."*

*"We have practical problems, we need practical solutions. Something we can do. When have these kids and families crying out for help. We need something we can do with them, not just someone to talk to but someone who can show us what to do."*

### Theme: Expectations (Box 5)

Expectations of what the participants perceived mental health consultation to offer were articulated through their description of hopes and/or beliefs. Some expected to be given advice including recommendations, suggestions, guidance and instructions to foster skill development and self-confidence, whereas others spoke of needing verbal reassurance that they were "doing OK". Once reassurance was given emotions such as relief, increased confidence and a sense of achievement were common features in the findings. On the other hand, some expected the opportunity to "offload", meaning that the consultant would be available to listen to all of the participant's issues, problems and dilemmas in the workplace. Descriptions of needing time for themselves, or having someone to turn to when they were feeling isolated or overwhelmed, appeared a common feature. A feeling of immense relief and "lightening the load" gives the impression of a great weight or burden (often described as stress) being lifted. Being able to talk in this manner facilitated the participants to not only cope better in their practice area but in their personal lives too. Examples of this include improved sleep patterns and reduced anxiety.

*Box 5*

*"I try my best, but sometimes I haven't a clue. Having somebody specialised in mental health is handy, especially if I've come to the end of my limits of what I can do within a school and I'm looking for more expertise, more for the family, for the kid."*

*"Often you feel as if you're floundering out here on your own. Having someone who I could just go blah, blah, blah to would be wonderful."*

*"Well it gets it off my chest straight away, it stops me going home thinking about it. Once I've offloaded, I can sleep at night."*

*"I feel swamped at times, and having some "me" time really helps. I'm not sure if that's what it's supposed to be for, but it helps me clear my head."*

## Discussion

This qualitative study aimed to investigate how professionals working directly with children and young people understand and use mental health consultation offered by CAMHS. Using general nurses who work within school settings as a representative population, the results contribute towards a greater knowledge base of how primary care workers understand mental health consultation. Of most significance is that of social and professional identity relating to how individuals identify themselves within a profession[32-33]. The findings identified how the nurse's sense of professional

identity shapes who they are in the world of child mental health practice and, in turn, how they felt the need to protect their established professional identity. In accepting the norms, values and rules that characterise their role as a general nurse working within a school environment, any changes to this role can cause discomfort and uncertainty. Having to consider and explore issues of mental health practice can become a threat to this core professional identity and result in feelings of powerlessness, anger, confusion and feeling deskilled. As Harmer[33] points out, expansion of roles and lack of clear boundaries between professionals can only lead to a further sense of losing their professional identity whereas others perceived the role expansion as a gain[34] believing the value and benefit of attending mental health consultation far outweighed the negative aspects.

Blurring of professional boundaries is a key factor regarding whether the participants understood mental health consultation as favourable or unfavourable. Clear parameters are needed to establish what each person will contribute to the care of the identified case under discussion in consultation, thus creating transparent boundaries for successful joint working as advocated by the Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA)[1]. However, this does not assist those participants who feel overworked and resentful when asked to become involved with mental health issues. For instance, the feelings of being overwhelmed by a predominance of mental health issues can result in a desire to defend "one's turf", with a fear that a blurring of the roles may result in a loss of professional identity as already discussed.

The findings both identified constraints that were real and perceived. For instance, it is a real issue that despite having clear directives of using mental health consultation, few resources are allocated to assist with the time and workload this creates. The participants, as with most workers in the primary care field, are under increasing pressure to take more onto their workload, so finding time to attend consultation often loses priority[35]. Only when national and local services support primary care professionals with appropriate resources will mental health consultation in primary health care truly be effective. In acknowledging this constraint, it also can be argued that even though participants discussed the issue of workload pressure, those who actively engaged in mental health consultation were able to articulate how attending consultation actively reduced their workload in the longer term by alleviating the stress of having to manage complex mental health issues in an isolated manner.

It is interesting to note the participants' understanding of what constituted mental health consultation. Rather than focus on the mental health needs of the child or young person, there was a definite focus on each participant's own needs. Colloquial terms such as "offloading" used by participants within the interviews could be argued to have many similarities with clinical supervision rather than mental health consultation. "Offloading" conveys a personal motive, such as accessing support for personal emotional wellbeing, though it is difficult to ascertain whether this also incorporates the practice of self-reflection as a quality tool to improve practice. Though clinical supervision recognises that often personal issues can affect work practice and sometimes cannot be ignored, when the focus becomes more about the supervisee rather than a practice issue, a strong recommendation to seek personal counselling is usually recommended. The fact the consultant would highly likely be trained in mental health and skilled in counselling may misguide the consultee to assume consultation was for this purpose. Salmon and Rapport[36] found similar findings in their research on multi-agency working relationships, reporting that when some professionals felt unsupported and were receiving inadequate supervision within their own agencies, meetings set up for case consultation appeared to turn into personal supervision. This begs the question of what kind of support the participants were expecting and how this then affected their understanding of mental health consultation, despite consultation, clinical supervision and "offloading" being three very different concepts. As support comes in a variety of forms[37], part of the process of understanding mental health consultation is determining what type of support is required and if consultation is the correct forum to receive it. Regardless of this, anecdotally it could be argued that those primary care professionals who attend mental health consultation are, in fact, providing a better service to the client by actively engaging in the process (whatever their understanding) as they themselves feel supported.

Feeling overwhelmed by mental health issues and requests from the consultant to be actively involved in interventions could go some way to explain levels of resistance seen in the findings. A lack of confidence, of not knowing what appropriate action to take, often instigated feelings of helplessness and being "out of their depth", whereas, for those who used consultation, a greater sense of self-confidence emerged, trusting their ability to perform. This demonstrates self-awareness and an emerging sense of professional development through reflective practice. If primary care workers can be educated that mental health consultation can have a positive impact on practice, then perhaps the

negative aspects of it, and the assumption that it is inherently not worth partaking in, can be challenged. Stakeholders must also play their part in allowing primary care professionals to actively engage in mental health consultation by recognising the gap between the desire to expand the professional role and the realities of workload and clinical capacity[38].

Also related to issues of confidence, emerged the participants' lack of an appropriate knowledge base from which to work. In this small study there was a belief confidence increased due to an increased ability to identify mental health problems via having undertaken the appropriate training. In 2006, Watson reported that the biggest component of mental health consultation for paediatric wards soon became teaching and education with staff demonstrating a commitment and awareness of their educational needs[39]. Likewise, the participants were clearly able to identify their learning needs with strong enthusiasm for any future training on offer. Sharrock *et al.*[20] advocate that education topics offered should be negotiated and selected from the requests of the primary care staff and should include both written and critical reflection scenarios to improve the expertise of the staff.

Current reforms in Australia suggest that mental health professionals will take on more consultative and educative roles in addition to their usual clinical care roles[4]. Although targeting education makes practical sense, it also raises concerns that those least motivated for further education may be those whose skills are in most need of improvement. Regardless of this, upskilling and supporting the primary care workforce, such as school nurses, is a logical solution to addressing the increasing prevalence of mental health issues in children and young people.

## Limitations

Although qualitative research allows the development of rich description, the use of a small, purposive sample of participants, all employed in one local area, means the study is not without limitations. These include external validity and the generalisability of the study. It is acknowledged the research is unlikely to be wholly representative of a school nurse population or other primary care workers and any inferences made are purely speculative. The focus of this small-scale study was to identify and explore the experiences, opinions and perceptions of school nurses in order to develop rich description, rather than use sampling techniques that support generalisability of the findings.

## Conclusion

This research contributes to existing knowledge about mental health consultation by advocating that all individuals participating in mental health consultation should be encouraged to embrace the practice and understand what it actually means within the context of their own discipline. From this, primary care workers are then able to develop, maintain or rework their professional working identity to prepare them for the reality of consultation practice in their everyday working life. Acknowledging and accepting mental health consultation is an important practice for primary care workers in Australia will go some way towards dealing with the rising prevalence rates of mental health problems in children and young people[1]. Therefore, it is imperative that clear processes and structures are established to enhance not only mental health consultation but any multi-agency working relationships. Working across professional agencies will continue to become an increasing part of those individuals who work directly and indirectly with mental health issues. Developing and implementing guidelines will be one way to support this.

In order to address barriers that may hinder the uptake of mental health consultation decision-makers in all service systems should match current rhetoric about implementing it as a preventative strategy by considering appropriate and realistic processes about how it can be incorporated into the existing workforce structure. The provision of sustainable financial resources such as staff training, time, interprofessional education, evaluation strategies and research will go some way towards achieving this. Organisations can ensure a culture that supports effective mental health consultation by encouraging all stakeholders are included in the development and implementation of future policies, particularly in relation to role responsibilities, developing values, structures and processes, ensuring a balanced delivery of care and resources as needed

This research has demonstrated that mental health consultation is multifaceted, consisting of several elements that can promote or hinder its success in practice. Identification of an effective and comprehensive model could guide flexible, innovative and complete mental health consultation tailored to meet the needs of primary care professionals. Thus there is a need to develop, pilot and evaluate a consistent, systematic model to be able to support primary care workers and, thereby, children and young people with mental health issues.

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