Child Psychiatric Consultation Service to Community Agencies: A Collaborative Approach Involving Three Community Agencies

Arthur Froese, MD1, Patrice Dwyer-Sepic, MSW2, Kevin Parker, PhD3

Objective: To report the early experience of a multiagency child psychiatric consultation service.

Method: The program is described, and the demographic characteristics of clients referred to the consultation program over the first 25 months of operation are presented. Referrals were examined for demographics and the questions consultees wanted to have answered.

Results: In 59 of 100 consultations, physical and/or sexual abuse was proved or highly suspected. In 82 of the 100 cases, consultees had questions pertaining to management issues. Questions related to diagnostic issues numbered 62, and there were 45 questions about safety issues.

Conclusion: Effective psychiatric consultations services to rural areas can be established. Once established, the questions of consultees can provide an effective training ground for future community-oriented child psychiatrists.

Key Words: community child psychiatry, consultation, resident training

The Ontario Child Health Study estimates that the point prevalence of one or more child psychiatric problems in the province of Ontario is 18.1% (1). Especially in smaller urban and rural centres, few children receive direct assessment, diagnosis, or treatment in the form of medications or therapy from child psychiatrists (2,3).

To date, relatively little has been written about child psychiatric consultation in underserviced rural settings. Dubois and others (4) have offered some guidelines for the psychiatric consultant that would enhance the “multiplier effect” and thus empower nonpsychiatric practitioners.

Queen’s University provides consultation services to several rural communities and has developed a small but effective training program for medical students and psychiatric residents in the area of community child and adolescent psychiatry (5). The first 25 months of operation of one of these consultation services to a group of 3 agencies is described. The 3 agencies (2 children’s mental health centres—CMHC and a mental health agency—plus a child welfare agency [CWA]) serve a population of 98,300, including 25,350 children and adolescents.

Methods

The consultation service was established along the guidelines for consultant psychiatrists outlined by Dubois and others (4). Representatives of the 3 consulting agencies meet weekly to decide which clients and families most urgently need to be seen. Most consultation sessions begin with the psychiatrist and resident doing a complex, client-centred consultation. Later, a less complex client-centred case is seen, or the consultant meets with a consultee to discuss one or more cases for a consultee-centred interview. Referred clients must have a primary worker who shares background material with the consultant prior to the interview, generally sits in during the interview, and participates in the planning afterwards. On a few occasions, the consultant meets with a consultee to discuss any future cases in consultation. Referred clients must have a primary worker who shares background material with the consultant prior to the interview, generally sits in during the interview, and participates in the planning afterwards. On a few occasions, the consultant and resident met with agency representatives to review the service or met with an agency director as a program consultant around agency issues.

For this study, the files of the first 100 client-centred consultations were reviewed and the data collated and analyzed using statistics within the chi-square family (6). All reported differences were significant at the 0.05 level.
Results

In total, 36 clinicians from the 3 agencies used the consultation service. Nine of 11 CMHC clinicians made 45 referrals, with 17 of these cases also involving other agencies. Of 35 CWA clinicians, 23 made 37 referrals, with 23 of these involving other agencies. Four of 11 clinicians from MHA made 18 referrals, with 6 involving other agencies.

In total, 77 of the referrals were living with a parent: 47 with mother, 9 with father, and 21 with both. Seventeen subjects were living in foster care, and 6 were living with extended family. The CWA was involved with 13 of the 17 foster children. Exactly half of the referrals were male; preadolescent boys outnumbered preadolescent girls, but adolescent girls outnumbered adolescent boys.

In 59 clients, physical and/or sexual abuse was proved or strongly suspected. Both physical and sexual abuse was either proved or highly suspected in 21 instances. Typically, the abuse was quite severe. Overall, 40 children were victims of sexual abuse and 40 victims of physical abuse. Four of the victims were also perpetrators of sexual abuse. Gender did not predict the presence of abuse: of the 40 victims of sexual abuse, 21 were male and 19 female. Similarly, 21 males and 19 females were victims of physical abuse. The presence or absence of one type of abuse did predict the presence or absence of the other.

Consultees’ questions were tabulated under 3 broad questions relating to diagnostic questions, safety concerns, or future management issues. Since each case could have none or one or more concerns expressed in each category, numbers could total over 100.

Consultees’ questions regarding diagnostic issues were broadly categorized as questions about the presence and degree of depression (33% of cases), the presence of possible psychotic features (18%), and questions related to possible dissociative symptoms (19%). In 38% of the consultation requests, there were no diagnostic questions. The relatively high incidence of questions related to dissociative symptoms may be accounted for by the high incidence of sexual assault experienced by the clients.

Safety concerns were present in 45% of the consultations. Concerns regarding risk of suicide were expressed by 12 consultees, concerns about ongoing sexual abuse by 15, and concerns about physical safety were still present for 24 clients. Concerns about the safety issues did not vary significantly by agency. Social workers were more likely to have questions pertaining to diagnostic issues than were the community mental health workers.

Consultees’ questions regarding continuing management of their clients were categorized according to placement issues, issues related to therapeutic progress, whether medications might be indicated, whether referral for residential care should be considered, or what general treatment recommendations might be appropriate (Table 1). Questions about placement issues usually arose when there were concerns around safety issues: Is the child safe in his or her present home or should an alternative placement be considered? Questions about therapy were usually directly related to concerns about the therapeutic progress or, more likely, a lack of progress. Questions related to medications were usually about the use of antidepressants or stimulants. Concerns regarding residential placement were more frequently expressed on behalf of the youngsters thought to be manifesting either psychotic or dissociative symptoms.

Questions categorized under treatment were usually more general questions about the overall management of the case.
Social workers and community mental health workers tended to ask questions about therapy, medications, residential placement, and treatment with equal frequency.

Discussion and Conclusion

From the consultant’s perspective, the shared consultation service held the following notable features. First, clinicians from the initiating agency were the most frequent users of the consultation service. Second, the cases seen came from more disturbed and often more chaotic backgrounds than do the cases the consultant typically sees in his home agency. Of course, the consultations generally involved the most difficult clients on the case lists of the 3 consulting agencies. Third, the work, although frequently exhausting, was also quite rewarding in terms of the expressions of appreciation made by the consultees.

Because of the complexity of many of the referrals to this type of service, a consultant sometimes will not have much to offer beyond what is already being done. This can discourage an inexperienced consultant, but it should not. Such requests for consultation can be used to reassure the consultee that he or she is doing as well as is possible. It is often very valuable for the consultees to recognize that the “expert from afar” does not have anything further to suggest.

We found that it was important for the consultant to be familiar with the limits of local resources so that his recommendations were practical and could be carried out. Also, because 2 or more agencies were involved in some consultations, the consultant had an opportunity to help bring the agencies into a closer working relationship.

From the consulting agencies’ perspective, the shared consultation service had the following benefits. First, child welfare cases were often also clients of at least one of the children’s mental health agencies and sometimes of both. Second, all 3 agencies had some history of working autonomously without adequate collaboration between agencies, sometimes to the detriment of the client. The more complex cases, the psychiatric consultant was able to spell out and differentiate specific child welfare issues from the mental health issues. The service promoted greater interaction and coordination between clinicians of different agencies and thus more effective and efficient treatment planning. A third benefit of such sharing was its cost-effectiveness. By sharing the cost of the consultant, each agency was pleased that it was able to receive some psychiatric guidance in a rural area at a very nominal fee.

Clinical Implications

• A shortage of child psychiatrists implies the need for community-based consultation models of care.
• Agencies in smaller, underserviced areas can share consultants effectively.
• Consultants can expect questions regarding management, diagnostic, and safety issues (in that order of frequency).

Limitations

• Funding models and convenience make child psychiatrists reluctant to leave their offices for underserviced areas.
• It is difficult for several agencies to enter into cooperative consultation services and outcome studies.
• This is a case study of a single consultation service.

References


Résumé

Objectif : Faire état de l’expérience initiale d’un service de consultation en pédopsychiatrie interorganismes.

Méthode : On décrit le programme et présente les caractéristiques démographiques des clients dirigés vers le programme de consultation pendant les 25 premiers mois de fonctionnement. L’aspect démographique des orientations et les questions posées par les personnes dirigées font l’objet d’un examen.

Résultats : Dans 59 consultations sur 100, on a vérifié ou fortement soupçonné la présence de violence physique et (ou) sexuelle. Dans 82 cas sur 100, les personnes ayant consulté posaient des questions à propos du traitement. Parmi les questions, 62 portaient notamment sur le diagnostic et 45 sur la sécurité.

Conclusion : La création de services efficaces de consultation en psychiatrie est possible en milieu rural. Après leur établissement, les questions posées par les personnes ayant consulté pourront devenir un moyen de formation efficace des futurs pédopsychiatres qui s’intéressent aux besoins communautaires.