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CARMEN PINTO

Differences between specialist community adolescent mental health teams and generic child and adolescent mental health services: training issues for specialist registrars

Following the National Service Framework (Department of Health, 2004) recommendation of extending the age range of child and adolescent mental health services to 18 years there is an increasing expectation that these generic services will provide the comprehensive care for severe mental health problems in areas where specialist teams do not exist. Services have responded to this with a variety of teams from generic adolescent teams to smaller first-onset psychosis or assertive outreach teams.

As a specialist registrar I worked in a variety of child and adolescent mental health services. Although each team has its own philosophy and approach, they also have many commonalities. It was at the end of my training, when I worked in an adolescent service, that I realised the services specifically designed for adolescents have striking differences from general child and adolescent mental health services.

Team description

The aim of the adolescent service is to provide a comprehensive community mental health service for young people aged 14–18 years. Priority is given to the most disturbed of the client group: adolescents with first-onset psychosis, those at risk of self-harm, those whose distress threatens home placement or their placement in 'care', and disadvantaged groups (e.g. children of parents with mental health problems and the increasingly more frequent group of unaccompanied adolescents with asylum status) (Goldberg *et al*, 1997).

As well as the out-patients facility, the service has three other interconnecting aspects: day programmes, group programmes and an outreach structure. The day programme (classroom-based in the morning and group-based in the afternoon, linked with individual therapeutic sessions) offers an opportunity for intensive intervention for those adolescents not benefiting sufficiently from out-patient work. The specialist registrar is welcome to co-run one of the groups for out-patients or even create a new one depending on special interests and service needs. The outreach aspect of the service is related to the team's philosophy of going out of its way to become involved with the troubled young person, meeting whoever is worried and wherever is most convenient (e.g. in their homes, schools, general practitioner surgeries or community centres). The team places strong emphasis on consultation with schools or institutions working with distressed adolescents, such as those in children's homes.

Staffing consists of up to 11 full-time equivalents, including three social workers, three specialist nurses (one in drugs and alcohol misuse), an occupational therapist, a housekeeper, two secretaries, a teacher, an educational psychologist, a clinical psychologist, an adolescent psychotherapist, a consultant adolescent psychiatrist and a specialist registrar.

What does 'adolescent-friendly' mean?

The service claims to be 'adolescent-friendly' because it continuously adapts frameworks to meet the current situation, as this will change from meeting to meeting. Other specific issues of working with adolescents include the following.

Using the engagement–negotiation model

Engaging the young person is often the presenting problem, and seems to be prioritised over the reason for it. This need for maximising engagement by constant negotiation led to the development of the engagement–negotiation model (Goldberg & Anthony, 2004). The first key issue to engage adolescents is avoiding a long waiting time (Griffiths, 2003), so the service has a no-waiting-list policy.

We aim to make the first contact by phone with the adolescent as soon as possible to introduce ourselves. In this phone conversation, we also negotiate the timing of the first meeting and with whom and where we should meet, possibly changing the initial request to a more preliminary consultation. It is important to be flexible, and

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follow the demands of the situation in meeting whoever wants to meet us without insisting on meeting those who do not. This has given rise to requests for both parental counselling when the adolescent refuses involvement, and for strategic interventions with adolescents when parents or professionals disengage. Sometimes we enrol family members and professionals that have not attended with a phone conversation that everybody in the room can listen to with a loudspeaker. A personalised letter is sent if we cannot reach the adolescent by phone. It is not necessary at this stage to talk about the problems outlined by the referrer, but to acknowledge that he or she is worried about the young person.

After every session, negotiation of the next step is a key factor in the development of an effective joint working alliance. Care plans are likely to be revised frequently as goals of intervention evolve. Letter writing after sessions helps to continue the debate about the adolescent's predicament between meetings (Goldberg, 2000) and to emphasise the care plan.

Working flexibility and working with risk

As with other mental health services, we struggle with the management of emergencies within more routine work. However, as changed, cancelled and unscheduled appointments are a frequent occurrence in all adolescent work, this allows a certain degree of flexible working, provided that staff availability is known within the team. Working late three evenings a week also helps to reach some adolescents and their families.

Risk assessment and management is a requirement of clinical governance. Specialist registrars working in adolescent mental health services will find that sources of particular risk with this age-group are issues of confidentiality *v.* safety (getting the right balance to maintain engagement and keeping the adolescent safe), giving or not giving a diagnosis and medication (which can be helpful or stigmatising). The most common risk an adolescent psychiatrist will have to assess is that of self-harm and suicide. Harm to others is more frequent in adolescent mental health than in children's, and it is important to remember that adolescents are still vulnerable to all categories of abuse (Subotsky, 2003).

Mutual teaching within and outside the team

The team focuses on each member of the multidisciplinary team maintaining their professional integrity through mutual teaching and examples of good practice. Co-working acts as the informal approach to this. A more formal approach is founded by evidence-based practice following clinical governance (Graham, 2000). Initiatives, such as the FOCUS project (http://www.focusproject.org.uk), with its evidence-based briefings (Royal College of Psychiatrists' Research Unit, 2001), contribute to being up to date with the best available evidence.

Discussion of complex cases, particularly those concerning young offenders, adolescents with learning disabilities and unaccompanied minors are reasons for inviting members of other agencies to comment on our activities or to co-work with us. At these meetings, gaps between agencies and unmet needs are recognised, as professionals are going to be asked to provide services for groups of adolescents for whom they have not been or do not feel adequately trained. The role of the psychiatrist will be defined by the management and treatment of severe mental illness, in which they may not have had much experience since their original training. The answer for these gaps is the development of appropriate training experiences, which may be gained by co-working or buying in supervision and consultation from another service (Griffiths & Lindsey, 2004).

Conclusion

Working with distressed young people is difficult, often requiring 'thinking on your feet'. Having the capacity to adapt to ever-changing situations, to focus on the process and to see every apparent setback as an opportunity to learn requires enthusiasm. I found that a specific adolescent team is structured to meet the vicissitudes of adolescent life and the complexities of the interface with many organisations (Bruggen & O'Brien, 1986). There is much to be gained from the experience of mental health teams specifically designed for adolescents for trainees to take with them into their future work in generic child and adolescent mental health services.

Declaration of interest

None.

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Carmen Pinto Consultant Child and Adolescent Psychiatrist, Lambeth Adolescent Team and Children Looked After Service (CLAMHS), 35 Black Prince Road, London SE11 6JJ, e-mail: Carmen.Pinto@iop.kcl.ac.uk

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