Paediatric Mental Health Liaison
First principles and guidelines

• Paediatric mental health liaison is the active collaboration of mental health staff with child health doctors, nurses and their colleagues. The primary task is to improve the care and health of their patients through the integration of contrasting viewpoints and interventions.

“CAMHS Paediatric Liaison (CAMHS-PL) is concerned with providing a bridge between acute paediatrics and psychiatric and psychosocial care. This is an essential service for the ill child, siblings, parents and carers in cases where the presenting illness has a psychological component, or where psychological distress is caused as a result of the illness.”

Department of Health 2006¹

• Liaison means joint meetings of some kind, which includes work with patients and their families, directly with staff, and with both together.

• because ways of working have varied from place to place there is a variety of configurations and provisions around the country, yet the guiding principles are the same in every case. Any mental health presence in a medical setting has to deal with a boundary between different ways of thinking and working.

While commissioners naturally focus on which patients are seen and what treatments they receive, a necessary condition of effective liaison is a good and stable relationship between multidisciplinary mental health teams and their paediatric colleagues. This is best achieved when mental health teams are co-located with paediatric ones. Community CAMHS can only provide liaison services with specific training and skills, and dedicated sessions for the task.

• Funding of liaison services varies but guidance is clear that it must be secure. If commissioners of paediatric services have no knowledge of, or interest in, paediatric mental health there is a risk to the viability of liaison.

“Too often CAMHS-PL have insecure funding, with no local champions and are therefore vulnerable.”

Department of Health 2006¹

• Variation in practice exists as to which patients are seen. Some liaison teams do not see emergencies, but the entire range of work would include services for children of all ages from conception to 18th birthday, using assessment methods that can incorporate information at any level from the social and educational to the molecular.

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The following categories are a useful checklist

1. **emergencies** (self harm and psychiatric crisis, combining medical and psychiatric care).

   "Commissioners of acute paediatrics and emergency care must include the provision of appropriate child and adolescent mental health care by these services in their contracts if young people’s poor experiences of crisis responses are to be improved”

   *National Advisory Council for children’s mental health and psychological wellbeing, final report to Ministers 2011*

2. **medically unexplained symptoms** at all ages from infancy to adolescence (somatization/conversion, failure to thrive and regulatory/attachment disorders of infancy, chronic fatigue, pervasive withdrawal, fabricated and induced illness, any other unidentified mental disorder in a paediatric patient)

3. **long term and life-limiting illness** ((treatment adherence, associated mental disorder, school problems, parental and sibling stress, reduction in hospital admissions)

   "Living with a severe physical illness impacts on young people themselves, their emotional and social development, and their families. Children living with long term physical illness are twice as likely to suffer from emotional or conduct disorders.

   There is considerable overlap between children with medically unexplained symptoms and long term conditions, with both being significant risk factors for chronic mental and physical ill health in adulthood. In addition, approximately 10 per cent of children and young people frequently experience somatic symptoms not fully explained by medical assessments yet which cause significant impairment.”

   *NHS Confederation 2012*

4. **staff support, development and training** (attendance at routine staff meeting, ethics of palliative care, teaching specific courses, review after death of patients, etc)

5. **psychiatric symptoms of physical disease** (metabolic, immunological/infectious and brain disorders, drug-induced behaviours, etc)

6. **eating disorders**

7. **elimination disorders** (resistant encopresis and enuresis)

8. **post traumatic states** (serious burns, accidents and injuries, post major surgery e.g. transplants)

9. **anxiety about procedures** (needle phobia etc)

10. **work with anxious, depressed or bereaved parents of paediatric patients**

11. **work with parents and staff in neonatal intensive care units**

12. **therapeutic support for children of parents who have died or are seriously ill** in other hospital departments

13. **paediatric mental health has a significant part to play in perinatal mental health services**

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2 *Making children’s mental health everyone’s responsibility* NAC final report to Ministers, 2011 para 3.2

Appendix

**Delivering Good Practice**

- Whether CAMHS is provided by the same trust as paediatric services or by a different organisation, the professionals in both teams work together in an integrated way to support children and families and promote their mental health.

- Commissioners ensure that such links exist, and that where CAMHS and paediatric services are commissioned by different teams, all relevant commissioners collaborate in respect of paediatric liaison and in apportioning the cost to the various budgets.

- The paediatric liaison team is multi-disciplinary, providing both direct and indirect clinical work, staff consultation and support.

- Generic assessment and management of psychiatric problems, both full and sub-syndromal disorders are available.

- Training for CAMHS and paediatric staff is provided.

- Expertise in psychological management, psychopharmacology and social management including child protection is available.

- Liaison arrangements are made for the management of A&E services including deliberate self harm and acute psychiatric presentations; child protection; Neonatal Intensive Care Unit (NICU) and Paediatric Intensive Care Unit (PICU) and for complex, impairing, life threatening and long-term illness.

- The team is situated within the paediatric unit to allow easy and prompt referral and access.“

Promoting the Mental Health and Psychological Well-being of Children and Young People

*Department of Health 2006*

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“... children and young people with medical illnesses are at an increased risk for emotional disorders. At times, the emotional and behavioural symptoms can be the early manifestation of the medical illness... Integrated working between general practitioners, generalist and specialist paediatricians, psychologists, child psychiatrists, specialist nursing staff and other professionals is encouraged while looking after young people with chronic physical, neurodevelopmental or life threatening illnesses.

This has been particularly emphasised in the care of young people with diabetes, cancer, respiratory conditions and epilepsy. There is growing evidence base to support this in terms of improving treatment adherence, treating procedural anxieties and improve coping with the illness within the family.”

**Improving physical and mental health**

*RCPsych, RCPCH, RCP, RCPGP 2012*

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“Attention to the mental health of the child, young person and their family should be an integral part of any children’s service, and not an afterthought.”

**Getting the right start: National Service Framework for Children. Standard for Hospital Services (4.2)**

*Department of Health 2003*

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1 [http://www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh/childrenandyoungpeople.aspx](http://www.rcpsych.ac.uk/mentalhealthinfo/improvingphysicalandmh/childrenandyoungpeople.aspx)