

# Liaison and co-operation between paediatrics and mental health

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## Abstract

Mental health liaison with paediatrics is vital but often misunderstood. Anxiety about the stigma of a referral to mental health cannot be entirely eradicated. The best antidote to this inevitable tension is to have mental health staff working in the same premises as paediatrics, so that colleagues can get to know and learn from each other. When this is achieved there is a far greater opportunity for enriching the care that children and their families receive in hospitals and clinics, and for promoting liaison more widely. Paediatric liaison is not only for mental health problems.

**Keywords** child and adolescent mental health; deliberate self-harm; multidisciplinary paediatrics; paediatric liaison; prevention; professional anxiety; risk management; somatization; stigma

## The process of mental health liaison

Liaison is a relationship. In hospitals relationships are of course everywhere but are not regarded as a primary task of the service. The orthopaedic department will respond to a referral by offering to see the patient. A paediatric liaison service is more likely to ask questions about the process of getting there. “What precisely is the concern that you have about this patient?” “Do the parents or guardians know about this request, and do they want us to get involved?” “What is the history of this problem and have any mental health or psychological services been involved before now?”

This kind of self-consciousness is at odds with ordinary practice in NHS hospitals and may confuse or irritate the referrer who just wants the problem seen to. Yet by putting some of the onus back to the team dealing with the patient it is possible both to increase their understanding of the patient’s life and difficulties and also the chances of the referral being successful. Most mental health liaison clinicians have experience of referrals they have received that it turns out have not been discussed with the patient or the family. The result is frequently non-attendance. The problem here is stigma, and it will not go away.

A child or young person in paediatric care who is perceived to have a psychological or mental problem puts the medical and nursing staff on the back foot. They may feel that asking the patient to see such a specialist is rejecting, even insulting. This is as much to do with the practitioner’s prejudices as with the

patient’s. A great deal of work done by liaison teams is intended to normalize their work, including doing joint consultations, so that their colleagues can see for themselves what may otherwise be mysterious.

There is another way of writing about paediatric liaison, which is to ignore these impediments and simply describe the kinds of disorders that are encountered by mental health practitioners in paediatrics. That is necessary here too, but not at the expense of pretending there is no cultural gap between our ways of looking at child health.

## Two cultures

People who are perceived to have mental health problems are regarded differently from other patients. The problem is somehow not regarded as ‘real’. There is some sense in this prejudice, because one solution to many psychological difficulties is psychological change; there is something you can do about it yourself. If on the other hand you are a patient visited with a disease – a lesion somewhere in your body – it is assumed there is little you can do about it without medical intervention. There is in fact a spectrum of states in between these poles. The experience of most diseases can indeed be modified by thinking differently about them, but at the same time may respond to drugs or surgery. While the proportions vary, our intuitive judgements tend to settle near one end of the spectrum or the other: either the patient is properly ill, or he or she has a problem which is not really medical. The latter is the point at which a mental health professional may be consulted.

Table 1 lists some of the concepts in each culture, whether perceived by the other or by themselves.

## Strategies for dealing with the cultural gap

The reflections above are familiar to most who work in child health, but are rarely articulated. Clinicians may think that the stigma of mental disorder is now of historical interest only, or at least that it ‘does not happen here’. This is a dangerous

### The cultural gap

‘Medical’	‘Mental’
Patient	Agent
Diagnosis	Assessment/formulation
Disorder	Problem
Innocent – ‘can’t help it’	Wilful – ‘should behave differently’
History/data/information	Narrative/knowledge
Investigation/test	Inquiry
Lesion	Syndrome
Biological	Psychological
Objective	Subjective
Material	Immaterial
Pain	Pain
Procedure	Experience
Fact	Feeling
Linear	Circular

Table 1

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assumption, because it happens everywhere, including in the minds of mental health practitioners ourselves. We are not missionaries aiming to defeat stigma; we are engaging with it. We want to demonstrate to paediatric staff that we are readily accessible to their requests, that we do not mystify our craft, that we are not blaming them for their management of the case and that we are keen to learn more about any medical condition that the child has. Anxiety about psychological problems arises because the doctor or nurse is not expert in this field, and because a referral may be made only after they have failed to establish the cause of a child's symptoms.

*A 12-year-old boy presents with repeated abdominal pains and nausea that started around the time of transfer to secondary school, since when he rarely attends. Apart from a few borderline results, all investigations are normal, yet the symptoms persist. Reassurance that there is nothing wrong does not work, because something clearly is wrong. The paediatrician requests an opinion from a child psychiatrist, who enquires about the child's history. The child was born by caesarian section a month prematurely and was in the special care baby unit for a few days with jaundice. His development has been otherwise normal. The child psychiatrist asks the paediatrician to invite both parents to a consultation to be conducted jointly by the two specialists.*

*The problem of the referrer is that he or she feels relatively inexperienced while the newly engaged expert asks quite different kinds of questions in the interview. There are also new people to meet, since this is the first time the father has ever attended a consultation with his son at the hospital. Father says that he leaves dealing with doctors to the child's mother. She is very anxious, while he seems rather distant and looks at his watch in case the parking meter runs out.*

*The paediatrician is not comfortable. The psychiatrist, sensing this, emphasizes to the family how important it is that all the medical tests have been done. "This way I do not have to worry about missing a physical disease. My colleague has helpfully ruled that out, or are you still worried about that?" In this way the psychiatrist is an advocate for the family, at the same time making it clear that the paediatrician is still very much needed. Mother says she continues to worry, but goes on to say that she has been preoccupied with her own elderly mother's diabetes and hypertension in recent months. She sees no connection between that and her son's pains. Father has been uncertain about his job during this time, fearing redundancy. Mother says she has always worried about her son's health because of the circumstances of his birth.*

Not all collaborative clinical work need be done in the presence of the referring doctor or nurse, but it is necessary from time to time, especially when the cause of the symptoms remains unclear. Joint work demonstrates to all involved the need for at least two points of view when attending to complex clinical problems. These are rarely entirely physical or entirely psychological. Liaison creates a triangular relationship, with two professionals looking together at one patient and his family. This replicates a basic pattern in the life of a child where there are – at least in his or her mind – two parents who inevitably and necessarily see things differently. The difference may not be comfortable. Liaison is difficult because disagreements will occur between medical and mental health staff, just as they do between parents.

Liaison varies greatly from one place to another. Some psychiatrists working in paediatric departments become very skilled as behavioural paediatricians, where their effectiveness depends more on specialist diagnosis and medication than on joint work with staff and psychotherapeutic contact with the patient and family. Child health psychologists have in many places kept clear of psychiatrists and developed an identity and a literature of their own. Child psychotherapists, family therapists, mental health nurses, social workers and others have also established good partnerships with paediatricians. The fact that there is such a variety of ways of approaching mental and behavioural problems in child health reflects the opportunistic way in which services were set up, through what were in effect professional friendships. The historical evolution of these arrangements (if they exist at all) is not necessarily an indication of different needs.

### **Hierarchies of needs, hierarchies of skills**

Hospitals are very expensive and health service commissioners typically attempt to build up community provision to keep people out of them. As the boundary between the two becomes blurred so does the difference in skills. The modern NHS is focussed on commissioning community services for young people and their families, including children with physical symptoms or diseases. This can confuse the users of the service.

If our 12-year-old boy with abdominal pains is referred to a psychologist or psychotherapist attached to his school [supposing he can get there] he is unlikely to be seen together with the doctor (paediatrician or GP) who is investigating the symptoms. Communication between mental health practitioner and doctor may instead be by phone, or by letter, email – or not at all – which means losing the benefit of a meeting where each can negotiate precisely who is doing what. Given the subliminal anxieties and prejudices that arise in somatization disorders, there are many more opportunities for making erroneous assumptions when there is no face to face contact, either in the presence of the patient or separately. It is better to reserve mental health services in the community for patients who do not have medical symptoms or problems that could interfere with their treatment.

National guidelines consistently emphasize, firstly, the need for liaison services to be co-located with paediatrics so that colleagues can meet regularly both in scheduled meetings and informally on wards and in corridors and, secondly, that the different disciplines in mental health should work together as a liaison team. This means that psychologists, psychiatrists, child and family psychotherapists, mental health nurses (and where possible social workers too) have their own meetings where they decide how to share out the work they are asked to do. How, otherwise, are paediatric staff to know which mental health expert they should refer their patients to? The referrer is, almost by definition, unclear about the precise nature of the problem and should not be expected to decide what intervention could help, nor which profession should provide it. Mental health professionals who work in separate departments on the same site create confusing – and potentially rivalrous – divisions, unhelpful to referrer and patient alike. However good any of these may be in particular instances, the persistence of split arrangements

(except in highly specialized units) has in general contributed to the poor reputation of paediatric mental health services.

### Unmet and unrecognized need

In recent decades there has been an enormous growth in child mental health epidemiology, so that it is now known without doubt that children with medical disorders have a greater chance of having a mental disorder too. A recent English study found more than double the rate of emotional and behavioural problems in children attending outpatient clinics compared to children in the community, yet clinicians identified only a quarter of these mental disorders. In addition chronic and life-threatening illness has an impact on the rest of the family which may be overlooked, particularly when the parents are very devoted to the child and always defer to the doctor. Ironically parents who make a fuss may be more likely to get the extra help they need.

This is a plea for multidisciplinary paediatrics, for liaison between many different professions working with sick children. The part played in this by mental health staff is facilitative. Hospital paediatrics is too complicated to work effectively without regular discussion meetings that are separate from ward rounds. These are variously called 'psychosocial' or 'multidisciplinary' meetings, and are easily mismanaged or neglected when pressure on beds and clinical time is high. A secure setting in which colleagues – doctors, nurses, hospital teachers, social workers, mental health staff, play specialists, community nurses, speech and language therapists, physiotherapists, etc. – meet week after week is very different from the more traditional medically led ward round process; complaint–history–examination–diagnosis–treatment. If senior clinicians of all disciplines support this event by attending regularly, they can create a space for reflection which becomes an essential part of the working week, not an added extra. Here is an opportunity for individuals to take the risk of speaking their minds about a patient and his family, especially when it is a worrying or troublesome case. Nurses may have concerns about a parent's mental state, or about the safety of a child, for example. Voices that are at other times silent are heard, to the benefit of the child's overall care. A similar space is provided in meetings to review a recent death on the ward or in the emergency department. Even though many clinicians feel they should be able just to carry on and forget it, most appreciate the chance to talk in confidence about their experience of a death and, if the child was well known to them, their attachments to the child and family. Even when no errors have been made, expressions of guilt are common. As they learn from, and sometimes disagree with, each other, staff in a work discussion group acquire a richer view of the practice of hospital care. Successful liaison/collaboration means respecting both cultures while acknowledging that the medical one is, as it should be, almost always dominant.

*A teenager with sickle cell disease is on the paediatric ward crying out for pain relief. In the multidisciplinary meeting there is some reluctance to talk about him because there have been quite tense moments between nurses and doctors on the ward. Some say he is asking for more opiates than he needs, while others feel that this is a subtle (or not so subtle) form of racism and that his real distress*

*is not being acknowledged. His mother, who also has sickle cell disease, has not helped by being so demanding herself. There is no disputing the diagnosis here. The problem is how to coordinate pain relief. Even if there are pain specialists in the hospital, they will have to work with their colleagues on the ward to reach some consensus about this young person before he gets the care he needs.*

Over many decades paediatricians, psychologists, psychiatrists and others have gathered an impressive array of evidence of effective psychological interventions in chronic conditions such as asthma, diabetes and sickle cell disease but research evidence alone rarely creates funding for new services. The pressure for that usually comes from crises that cannot be managed at all without mental health intervention.

### Emergencies

*A 15-year-old girl takes an overdose of paracetamol and is admitted to a paediatric ward following presentation at the hospital emergency department. She is not sure how many tablets she took – maybe 25 – but is clear about when she took them. She tells the admitting doctor that she had a bust up with her boyfriend, whom she says does not get on with her stepfather. Mother is at her wits end, struggling to deal with her daughter's older half brother who was arrested six weeks earlier in possession of a class A drug. The girl has been out of school for most of the past year.*

The commonest urgent admission that requires mental health attention is deliberate self-harm. Though a wish to die may occur at the moment of ingesting the tablets, suicide is not the primary intention in most of these cases. These young people are trying to escape from what seems to them an impossible situation, usually the result of a painful and lonely rift with someone close to them. They are expressing a form of rage that both attacks themselves and the person with whom they have argued.

The care of these patients has improved over the years. It gradually became clear that however bad their behaviour, there is no point in taking a punitive approach since nothing is resolved and they are likely to repeat the harm at the next crisis. An admission to a paediatric ward is therapeutic if the medical and nursing staff know that skilled colleagues will both support them, and also interview the young person and her family once any urgent medical interventions have been done. Deliberate overdose tends to occur in families with long-standing emotional struggles – and is over-represented in children who are looked after by local authorities – so that the goals of liaison intervention need to be modest. At least self-harm need no longer be the chosen way of managing a crisis in a close relationship.

A few of these young people are actively suicidal and may need transfer to in-patient psychiatric adolescent units. As so often in paediatric liaison the problem and its management are more important than the diagnosis. Decisions about whether they should be discharged or admitted to a specialist unit are based primarily on the risk of further self-harm, and of suicide. Rates of deliberate self-harm are much more frequent in girls (while suicide, very much rarer, is commoner in boys) and have been increasing. A thoughtful and collaborative paediatric, mental health and social work response may be the only opportunity for proper assessment of these young people, far too

many of whom are disappointed by the treatment they receive in hospitals. The impact of greater global migration is evident with the acute presentation of increasing numbers of young people of either sex, quite out of their depth, far from home, sometimes unaccompanied by any parental figures. The way a paediatric department manages deliberate self-harm is a measure of its success as a multidisciplinary service.

Less frequent than overdoses are young people presenting with psychotic symptoms. Provided they are manageable for a day or so on a paediatric ward, a medical setting is the preferred place to assess them. Only in a multidisciplinary paediatric department will it be possible to conduct medical, social and psychiatric assessments in parallel. Psychotic illnesses rarely appear out of the blue, but occur in young people who have had very disturbed social and family relationships for some years. Some of them will have organic disorders that can only be fully investigated in hospitals with skilled medical staff, imaging facilities and extensive laboratories.

### Making the case for collaborative services

Historically enthusiastic individuals have developed ways of working together in paediatric liaison that made the best use of available resources. If they have not been part of this experience paediatricians will be in no position to articulate to commissioners precisely what it is they require. In the absence of a liaison service it can be difficult for a doctor or nurse to judge when a mental health assessment or opinion is needed. If the patient has a chronic disorder that is getting out of control ('brittle' diabetes or asthma for example) it is not immediately apparent that psychological attention will do anything to help. Likewise in the management of so far medically unexplained symptoms there is always the possibility that another test will reveal the diagnosis. The child and family will often support this approach because physical symptoms such as pain, fatigue or weakness, do not in themselves suggest an emotional or behavioural cause, even if the child or parents are particularly distressed. Yet a respectful psychological point of view is usually helpful, whatever the diagnosis turns out to be. It is not always wise or necessary to have the child assessed by a mental health practitioner immediately. If a parent is excessively invested in the child's symptoms, for example, she may be slighted by any suggestion that these are not entirely physical. All the more reason for the paediatrician to have mental health colleagues close by with whom to debate the matter and devise a strategy.

These considerations make little sense to NHS commissioners, who feel obliged to ask for proof of effectiveness, and evidence that money might be saved, before funding new services. A case for mental health liaison can be made by using existing epidemiology: that a significant proportion of children with chronic disease will have mental disorders which will go untreated, thus impairing their medical management and quality of life. This is a start but will not include many other conditions also requiring support or intervention, such as chronic fatigue syndrome, medically unexplained symptoms, withdrawal and refusal states, somatization and conversion disorders, regional pain syndromes, eating and elimination disorders, confusional states and other complex conditions where physical and mental elements need to

be carefully teased out. These cases tend to split staff working with them, reinforcing the need for regular confidential multidisciplinary team meetings away from the bedside. After these discussions doctors and nurses may feel more confident to manage the case themselves, without needing to refer for mental health assessment. Where symptoms are exaggerated or fabricated by parents three way liaison that includes child protection social workers is required.

There are many other mental health needs of children in hospital. Early intervention for infants and toddlers with regulatory disorders – sleeping, feeding and crying problems – can break a cycle that otherwise leads to longstanding developmental problems. Children who have suffered physical and/or emotional trauma, in accidents, burns or major surgery, such as transplants, should have access to psychological care, but often do not. Likewise those whose parents are seriously ill or have just died in the hospital are usually neglected. Children with developmental disorders who have intercurrent illnesses may require mental health support or assessment when in paediatric care. Perinatal mental health is seriously underdeveloped in the NHS yet is the best opportunity in the life cycle to intervene both therapeutically and preventively. The long-term effects of antenatal anxiety and postnatal depression are still not widely understood or accepted. Finally the trauma to parents, and impact on the attachment process, of a very premature birth is often lasting. In all these situations collaborative work is both helpful to patients and their families and also of mutual benefit to clinical colleagues.

### Conclusion

The aim of this paper is to highlight the benefits of a good working relationship between paediatric teams and mental health services, while actively including professionals such as social workers and others working with children in the hospital. Collaboration is easy to recommend but hard to carry out. Traditionally the primacy of doctors went unchallenged, but a modern multidisciplinary approach is more complicated. Medical leadership is still just as important but has to be earned in discussion, sometimes in debate. National recommendations for better liaison have tended to be heard politely but are not acted on. Too many paediatricians have been disappointed, even put off, by liaison services for there to be a critical mass in the profession to speak up for better mental health provision for their patients.

Even when the service is available and responsive, there is still a cultural gap that repeatedly has to be bridged. While mental health staff must learn to understand and respect the primary task of medicine, the message we bring to paediatrics is that there is another aspect of the patient's experience that can also be attended to. It is as if child mental health practice had opened a previously unknown room in the paediatric house to reveal quite new kinds of anxiety and sorrow in the complex lives of children. ◆

### FURTHER READING EPIDEMIOLOGY

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**Practice points**

When referring a child or adolescent patient for a mental health opinion

- expect to engage in a conversation about the problem. 'Please see and advise' will not do
- do not at the same time refer the child to other specialists, or for other tests. It can confuse the child and family and undermine the success of the referral
- find ways of discussing your dilemma with child and parents. It is sometimes better to indicate that you are not sure what is required and want to engage your mental health colleagues to help you in your task, rather than simply refer on, as is usual when another opinion is required.