Paediatric mental health liaison
first principles, and misunderstandings

Though there are some successful mental health teams in NHS hospital paediatric departments around the country, their rationale and effectiveness are *invisible in policy terms*. This is so despite many years of national recommendations[1]. The following notes headline some of the issues.

"The whole point of liaison is to bring a variety of expert views to the problem simultaneously"

Principles and tasks of liaison

There are two key principles of liaison practice: *collaborative partnership* and *prompt response.*

There is widespread ignorance of how this works in child health. This is because there are so many paediatric departments where these partnerships do not occur.

In such places – and in the minds of policymakers, royal college officers and health service commissioners – it is difficult to imagine what it would be like. *"What kinds of mental illness do paediatric patients have?"* they may ask. While some paediatric patients do have serious mental illnesses the majority do not. They present with a range of common emotional and behavioural disturbances which from the child's and family's point of view feel like part of the physical problem.

The need for liaison arises primarily when medical knowledge cannot explain symptoms in a child – an infant failing to thrive, a schoolchild whose asthma is out of control, or a teenager with mysterious pains and weakness. These predicaments are *not mental symptoms*, yet psychological factors – frequently undetectable to parents and paediatricians – may play a part.

Alongside paediatric care what therefore also needs exploring is the developmental/ educational, behavioural, emotional and family life of the patient and how these influence the current presentation. For this a range of expertise is needed: *psychiatry, psychology, individual and family therapies and mental health nursing*. A well functioning liaison service will have at least three different disciplines in it.

Diagnosis on its own not much help

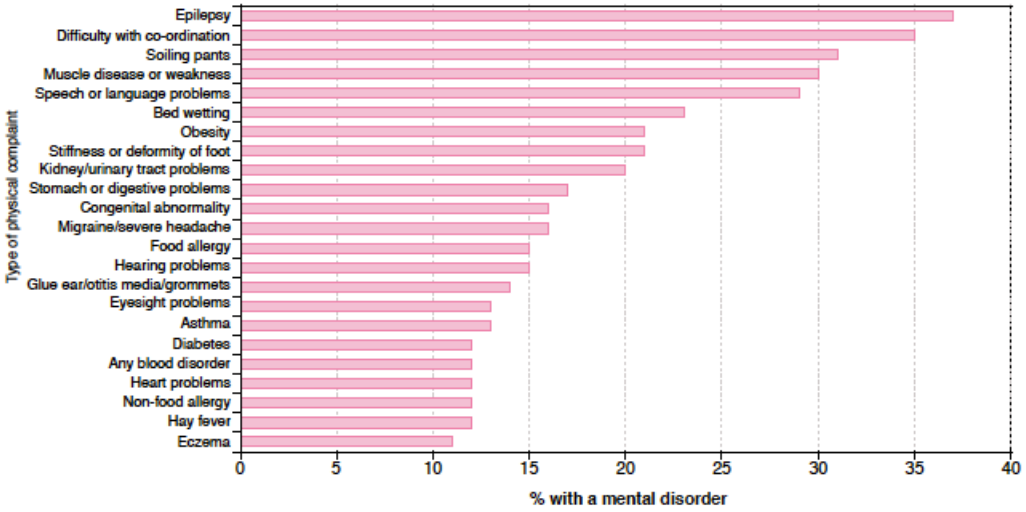
Simply identifying a child mental disorder from ICD10 does not usually get us very far. Mental and physical disorders in paediatrics frequently overlap, and either may present as the other, making the notion of a separate treatment for concurrent mental problems untenable. It makes no sense to the child patients either, most of whom feel that they have a medical illness.

[1] *National Guidance on Paediatric Mental Health Liaison* http://bit.ly/1Q7FzOq

"Compared with no physical health condition having any physical complaint increased the odds of having a mental disorder by 82%"
Meltzer et al 2000

In a survey for the Office of National Statistics (ONS)[2] Meltzer et al interviewed 10,438 children between 5 and 15 years old. Data collection included information gathered from parents, teachers, and the children themselves. The researchers used ICD10 categories to define mental disorder.

Figure 6.1 Percentage of children with a mental disorder by type of physical complaint



Meltzer et al 2000, p.74

As shown above the ONS survey identified significant mental disorders associated with physical complaints, the greatest prevalence being in children with neurological conditions. There are also quite high rates of mental disorder in children who wet the bed, had speech and language problems and soiled their pants. Apart from patients with epilepsy or other neurological problems (see appendix), the vast majority of these mental disorders were common emotional or behavioural problems.

Although asthma patients rated only slightly higher rates of mental problems compared to physically healthy children (13% v 10%), they were the largest single group of symptomatic children in the study. 1604 (16%) children had asthma; only 47 had diabetes. Current epidemiology shows that asthma in British children is almost 50 times more prevalent than diabetes[3].

Children who had accidents were more likely (14% v 8%) to have a mental disorder, the highest rate (25%) being found with accidental poisoning. 20% of parents of children

[2] Meltzer H, Gatward R, Goodman R, Ford T. (2000) *The mental health of children and adolescents in Great Britain*. London: Office for National Statistics.

[3] Around 9% of children in UK have asthma, the majority not needing hospital care. Prevalence varies throughout the UK, and death rates are significantly higher than in comparable countries in Europe. [Wolfe, I, Cass, H, Thompson, MJ, Craft, A, Peile, E, Wiegersma, PA, Janson, S, Chambers, TL & McKee, M (2011) Improving child health services in the UK: insights from Europe and their implications for the NHS reforms' BMJ 342, d1277., 10.1136/bmj.d1277] The current prevalence of diabetes in British children is 0.187%. [*HQIP & RCPCH: National Paediatric Diabetes Audit 2013/14: Report 1: Care Processes and Outcomes*, RCPCH 2014.]

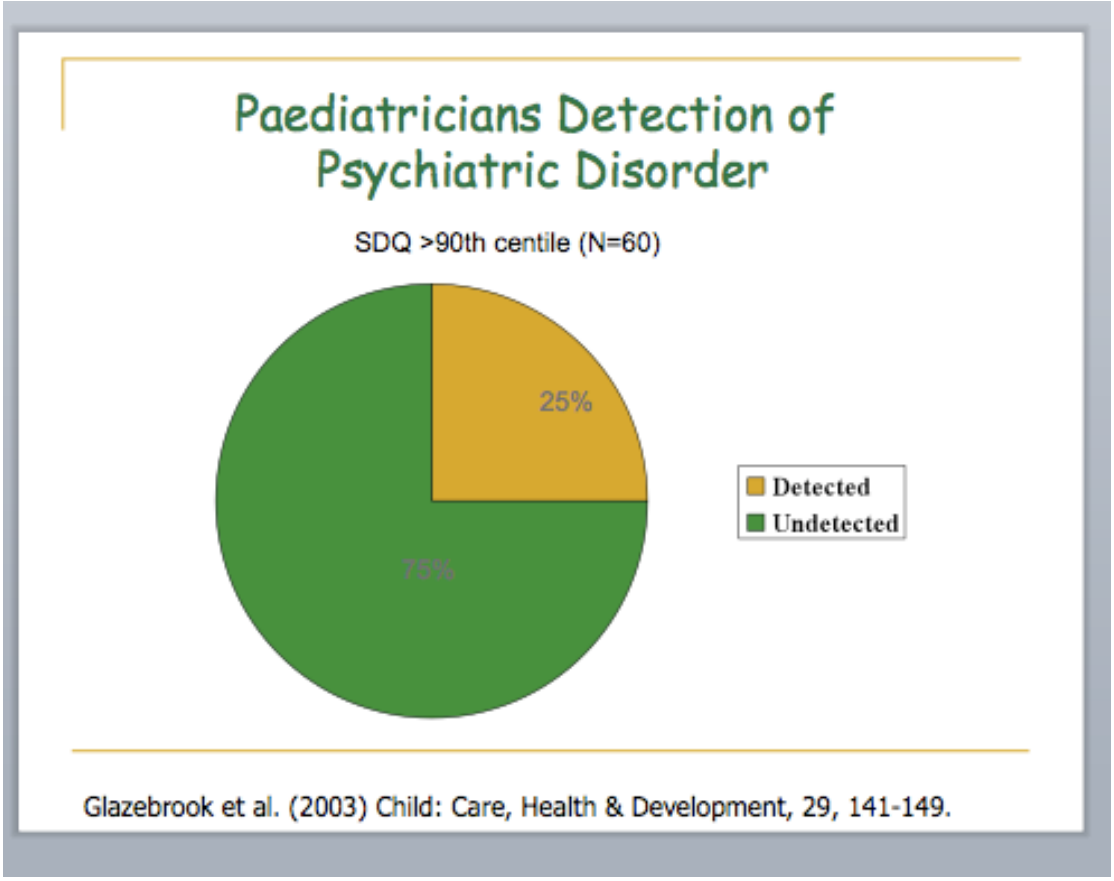
with mental disorders reported that their children were not in good health, compared with 6% of children without mental problems (p. 76).

Camouflage: mental disorders in paediatrics usually go unnoticed.
Only *half* of the parents in the ONS survey of children diagnosed with a mental disorder thought their child had a mental health problem

"Among the 928 children with a clinical rating on any of the three types of disorder, about a half of their parents thought their child had a mental health problem. This is a surprising result because a clinical diagnosis was only given to children where the mental problem had a significant effect on the child's life or caused distress to others."
Meltzer et al 2000 p75

In a separate but related study[4] of 305 children aged 5-15 attending a sample of paediatric out patient clinics:

"Clinicians only identified emotional or behaviour problems in a quarter of those children with parent-rated disorder"
Glazebrook et al 2003, p 141



[4] C. Glazebrook, C. Hollis, H. Heussler, R. Goodman, L. Coates (2003) Detecting emotional and behavioural problems in paediatric clinics *Child: Care, Health and Development* 29 (2), 141–149.

Mental disorder in children is frequently overlooked. In the absence of co-located liaison colleagues, the mental health needs of paediatric patients will not be met:

"Less than half of parents and carers of children with mental health needs or a physical or learning disability felt that staff definitely knew how to care for their child's individual needs. This compares to 72% of parents and carers of children without these conditions."
CQC, 2015[5]

"Children and young people with MUS are at risk of receiving suboptimal care and support"[6]

A study of paediatric staff's experience with patients who have medically unexplained symptoms noted:

"Making the transition from physical to psychological care was perceived as one of the most difficult stages in the professional–carer relationship because of parental resistance to giving up the notion of an identifiable, treatable physical cause for the symptoms in favour of an approach addressing psychological and social issues.

… referrals to psychologists and psychiatrists were perceived by parents as labelling their child as 'mad' or as 'obviously making it up' [citing OT; Nurse], and could permanently damage the relationship between practitioner and family."
Furness et al 2009 p579/80

A recent narrative review of the literature on medically unexplained symptoms in children notes that:

"referrals to child and adolescent mental health services are often a last resort when other approaches have failed".
Hinton & Kirk 2016 p13

Rather than leaving it until doctors feel defeated, and patients rejected, it is a better and more ethical practice to have colleagues on site with whom to discuss such referrals earlier.

Outcomes of paediatric liaison are paediatric

While it is important to identify unusual mental disorders in child health patients, it is clear that the majority have an excess of common and easily missed emotional and behavioural problems which compromise paediatric care, and must therefore be managed alongside it.

Given the relative obscurity of mental disorder in child health settings paediatric liaison outcomes are best seen as *paediatric ones* i.e. fewer out-of-control diabetics, epileptics and asthmatics, fewer extended hospital stays/repeated admissions and fewer intrusive

[5] Care Quality Commission (2015) *Children and Young People inpatient and day case survey 2014* key findings http://www.cqc.org.uk/sites/default/files/20150630_cypsurvey_keyfindings.pdf p.3

[6] Hinton, D. and Kirk, S. (2016). Families' and healthcare professionals' perceptions of healthcare services for children and young people with medically unexplained symptoms: a narrative review of the literature. *Health and Social Care in the Community*, 24, 12–16, p. 13, (p.12)

investigations for patients with unexplained symptoms (such as failure to thrive, feeding, sleeping and regulatory/attachment disorders of infancy, somatisation/conversion, chronic fatigue, pervasive withdrawal, fabricated and induced illness, resistant encopresis and enuresis).

Routine early intervention is better practice

In some diabetic clinics, eg at the Whittington Hospital in London, all newly diagnosed patients and their families are seen by a consultant psychiatrist based in the clinic. This is recognised in tariffs[7] paid for paediatric diabetic services and is becoming a more widespread practice. This reduces stigma and introduces mental health as an integral part of paediatrics.

Similar arrangement could be in place for other long term and life-limiting conditions in children especially asthma, diabetes, epilepsy and cancers.

Child health is more systemic than adult medicine

Though the basics of adult psychiatric liaison[8] look similar there are significant differences. Children are always part of family/carer and educational systems, and mental disorders are usually less established than in adults. Specific training in child and adolescent development is an essential part of a liaison mental health team's knowledge.

"the majority of children referred by paediatric teams had psychiatric problems that were often complex, involving physical illness or symptoms ... school absence was noted in a third of children, family dysfunction in half."
Garralda & Slaveska-Hollis 2016[9]

Co-location means learning from, and trusting, one another

Less measurable than medical outcomes are the equally important effects of mutual learning between mental and medical/nursing colleagues, creating a more sophisticated workforce that can manage complex ('difficult') patients and parents.

In both unexplained symptoms and acute mental emergencies parents may be unusually anxious, sometimes hostile. Anxiety is contained when parents and child can witness – and take an active part in – the working partnership between medical, nursing and mental health staff. This reduces 'splitting', which undermines treatment.

Splits are most evident in the paediatric management of *deliberate self poisoning*. Fear of suicide provokes anxiety in staff, but provided they are confident that skilled mental health expertise is available *at any time,* attentive work can be done by paediatricians at the point of crisis admission during the night, and then by nurses who look after the young people on the ward in a friendly and accepting way. This is the therapeutic essence

[7] "psychological support … should be integral to the team" *Paediatric Diabetes Best Practice Tariff Criteria* 2014 http://bit.ly/2jrdAiz

[8] *Liaison psychiatry for every acute hospital Integrated mental and physical healthcare* RCPsych CR183, 2013 www.rcpsych.ac.uk/files/pdfversion/CR183.pdf

[9] Garralda ME, Slaveska-Hollis K. (2016) What is special about a Paediatric Liaison Child and Adolescent Mental Health Service. *Child and Adolescent Mental Health* 21(2):96-101

of multidisciplinary care, which requires *routine mental health supervision and work discussion with doctors and nurses and others* caring for sick children.

Paediatrics is the emergency entrance to CAMHS
"Like sink estates, hospitals have become health policy 'no go' areas"

At the 2014 parliamentary health select committee inquiry into CAMHS none of the MPs were aware that the only service for psychiatric emergency is a hospital. There is still an expectation in NHS policy circles that better provision outside hospitals will significantly reduce emergency admissions. In the case of suicidal overdose, despite good research on social and psychological risks[10, 11], there is little evidence for this. Self poisoning is an impulsive act, and hard to predict. While it is vitally necessary to enhance community mental health provision for children, this could never replace the need for in-hospital mental health expertise:

"Hospitals in the modern NHS are regarded as expensive and unproductive, with most new funding directed towards providing services in the community. This well-intentioned trend has its limits, in that there will always be a significant minority of complex and urgent cases admitted to hospital beds or seen in hospital clinics.

Because some hospitals and emergency departments will close [as the NHS contracts] it is assumed that little attention is required to redesign the inpatient services that remain open. Like sink estates, hospitals have become health policy 'no go' areas."
RCPsych 2014[12]

Plans to provide out-of-hospital 'community' emergency care for teenagers in crisis are ethically dubious and risk missing serious illness. Young people with complex mental health emergencies and overdoses will in any case continue to present in hospital accident and emergency departments *because they have, or may have, urgent medical problems*.

When there is doubt about the nature of an acute disorder – is it delirium, infectious or immune encephalitis, drug intoxication? – a combination of medical and mental health expertise is required. There is no other resource as responsive and potentially capable as NHS hospital emergency and paediatric departments that work together, nor will there ever be.

[10] Gunnell D, Shepherd M, Evans M. (2000). Are recent increases in deliberate self-harm associated with changes in socio-economic conditions? An ecological analysis of patterns of deliberate self-harm in Bristol 1972–3 and 1995–6. *Psychological Medicine* 30; 1197-1203.

[11] Madge N, Hawton K, McMahon EM, Corcoran P, De Leo D, de Wilde EJ, Fekete S, van Heeringen K, Ystgaard M, Arensman E. (2011) Psychological characteristics, stressful life events and deliberate self-harm: findings from the Child & Adolescent Self-harm in Europe (CASE) Study. *Eur Child Adolesc Psychiatry* 20(10):499-508. doi: 10.1007/s00787-011-0210-4.

[12] *Parity of mental and physical child health in hospitals*. Submission by the Royal College of Psychiatrists Paediatric Liaison Network to the Parliamentary Health Select Committee inquiry into Child and Adolescent Mental Health Services (CAMHS) 2014. http://bit.ly/1SbJXMk

Short term integrated paediatric care can avert tier 4 admission

A few days' admission to a paediatric ward with co-located mental health staff can avert the need for a referral to a (tier 4) psychiatric in-patient unit, which often have no beds and are many miles away from the patient's home. As the crisis is explored and understood, suicide risk is reduced and clinical care can then be carefully handed over to mental health services in the local community.

The whole point of liaison is to bring a variety of expert views to the problem simultaneously

It is premature and unethical to expect staff at the front line to make decisions about whether a child has a mental or medical problem. This is often complex and cannot be left to teachers, ambulance staff or police officers, or even social workers. As the studies cited above showed, both parents and paediatricians routinely miss mental disorders in their charges.

Some physically ill children can be very disturbed, while medical patients with fabricated symptoms or conversion disorders may seem to have no mental problems. Without a careful 360º assessment (including social workers) *one can't always tell.* In many cases mental and physical disorders co-exist, as should the clinical services to manage them.

It is in any case not good for patients to be passed from one agency to another.

"No 21st century health system should require parents and children to go from place to place or even worse to go to multiple appointments to tell the same story."
Ian Kennedy QC [13]

Many paediatric patients will see no need for, nor attend, mental health appointments set up for them in another place. Uncertainty about diagnosis and management has to be held therapeutically by the clinical partners, not dumped on the child and family. In long term conditions partnerships may need to be maintained indefinitely.

The case for Paediatric Liaison has not been made, because it is not understood

Mental health services in paediatrics are often poorly provided (or not at all) and therefore few paediatricians – and fewer commissioners – will be in a position to know what would be most helpful. The effective camouflage of mental disorder in child health is a significant factor.

The Royal College of Psychiatrists' Paediatric Liaison Network noted with alarm that neither *Facing the Future for child mental health* (RCPCH et al, 2015) nor *Implementing the Five Year Forward View for Mental Health* (NHS England, 2016) were able to represent in any useful detail the mental health needs of paediatric patients and the resources required for paediatricians and nurses to care for them. The Paediatric Liaison Network's response to the latter report is at http://bit.ly/2dfL6Ti

[13] speaking at the launch of his review: Getting it right for children and young people. *Overcoming cultural barriers in the NHS so as to meet their needs.* September 2010, London: COI. (see BMJ2010; 341: c5129.)

Collaboration is required to commission collaboration

Variations in commissioning and funding reflect historical, opportunistic arrangements between medical and mental health staff, but it is now urgently necessary to have national consensus on the common features of effective partnerships between paediatrics and mental health.

"An example of excellent practice is a co-located, multidisciplinary service jointly commissioned and managed with paediatrics."
Royal College of Psychiatrists 2013[14]

Service specification for clinical partnerships cannot be defined by mental health specialists alone. The absence of paediatricians from ongoing detailed discussion of paediatric mental health liaison leaves it stranded and powerless to engage in establishing effective policy for enhanced paediatric practice.

[14] *Building and sustaining specialist CAMHS to improve outcomes for children and young people Update of guidance on workforce, capacity and functions of CAMHS in the UK,* RCPsych report CR182, 2013

Summary

A paradox: the need for hospital care is reduced by providing dedicated extra care in hospitals.

- **Multidisciplinary paediatric mental health liaison (PL) is poorly understood by those not involved in it. Despite numerous encouraging national policy documents since 2003 http://bit.ly/1Q7FzOq, limited progress has been made.**

- **Mental disorder is much more common in children with physical complaints than in children without such symptoms. Yet both parents and paediatricians significantly underestimate their presence. Because it is so often disguised as part of a physical complaint, on its own the diagnosis of a mental disorder is rarely a sufficient guide to clinical intervention.**

- **PL outcomes should reflect its impact on paediatric practice - better treatment adherence and control in long term conditions, reduction in admissions, in long stays and intrusive investigations for medically unexplained symptoms.**

- **It is not always a possible to decide in an emergency whether a young person has a mental or a physical disorder. Many acutely disturbed children and young people, including all of those those self-poisoned, need combined medical and mental health (and often social work) assessments until it is clear what is wrong and what further help is required.**

- **Short term emergency admissions to wards with co-located mental health teams can avert the need for expensive, disruptive (and often unobtainable) in-patient psychiatric beds.**

- **The patient and family's experience of good clinical partnerships is therapeutic in itself[15]. Without co-located mental health and paediatric care, clinicians, patients and families have little chance of appreciating the intimate connections between mental life and physical disease, which can occur in any health condition.**

- **Child health and mental health staff who have already been working together effectively must also collaborate in defining national standards for mental health and social services in hospital paediatric departments.**

Dr Sebastian Kraemer
sebastiankraemer.com
February 2017

[15] Kraemer S (2016) The view from the bridge: bringing a third position to child health in (eds.) Campbell S, Catchpole R & Morley D. *Child & Adolescent Mental Health: new insights to practice*. Palgrave Macmillan. http://bit.ly/1Ry2QHy

Appendix

Table 6.4 Prevalence of mental disorders by type of physical complaint

All children

	Emotional disorders	Conduct disorders	Hyperkinetic disorders	Less common disorders	Any disorder	*Base*
	Percentage of children with mental disorders for each complaint					
Epilepsy	17	18	1	10	37	*67*
Difficulty with co-ordination	13	17	10	8	35	*235*
Soiling pants	13	17	9	7	31	*116*
Muscle disease or weakness	18	10	8	2	30	*99*
Speech or language problems	12	15	7	6	29	*393*
Bed wetting	10	13	5	2	23	*484*
Stiffness or deformity of foot	10	12	3	1	21	*183*
Obesity	11	11	4	2	21	*84*
Kidney/urinary tract problems	12	10	4	-	20	*96*
Stomach or digestive problems	11	7	2	1	17	*629*
Migraine/severe headache	10	8	1	1	16	*513*
Congenital abnormality	6	4	8	3	16	*74*
Hearing problems	5	9	2	1	15	*429*
Food allergy	6	9	2	2	15	*370*
Glue ear/otitis media/grommets	5	8	2	1	14	*480*
Asthma	6	7	2	1	13	*1604*
Eyesight problems	6	7	2	1	13	*1097*
Hay fever	6	7	1	0	12	*976*
Non-food allergy	6	6	2	1	12	*581*
Heart problems	7	2	2	-	*12*	*128*
Any blood disorder	8	7	2	2	12	*47*
Diabetes	6	10	2	-	12	*47*
Eczema	5	6	1	0	11	*1289*

Meltzer et al 2000, p. 79