Parity of mental and physical child health in hospitals

*Submission by the **Paediatric Liaison Network**[1] (Royal College of Psychiatrists) to the Parliamentary Health Select Committee inquiry into Child and Adolescent Mental Health Services (CAMHS) 2014*

Summary

Despite a national commitment to parity of mental and physical health there is a continuing lack of dedicated mental health and psychological services to children and young people in hospital [appendix 1].

Introduction

The committee has received very many submissions about CAMHS but only a handful concerning paediatric mental health liaison, or psychological medicine, henceforth described here as *paediatric liaison.*

There are three main reasons for this.

1. No tier for liaison

Liaison with mental health never featured in the original 4 tier CAMHS structure created in the 1990s. We propose **tier 3¾.** These are services that operate within hospital paediatric departments, thus including the care of some quite seriously disturbed inpatients.

Besides emergencies there is a whole range of children and young people with unexplained or complex medical problems who would benefit from liaison interventions, were these available. Without this young people are deprived of care and treatment that they have the right to receive.

[1] Drs Anthony Crabb (chair) Sebastian Kraemer (vice chair) sebastian.kraemer@nhs.net, Michael Morton (hon secretary) 25 June 2014

2. 'Postcode parity' not achieved

Far too few paediatric departments have sufficient experience of timely and competent liaison[2]. Despite a steady stream of national policy recommendations and research in the past decade[3] there has never been a critical mass of first hand clinical knowledge of dedicated paediatric liaison teams in general hospitals.

The *'paradox of partnership'* is that hospital staff who have never received adequate liaison services are in no position to articulate to commissioners what they require. Frustration with absent or poor resources is not knowledge!

3. hospitals relatively neglected in policy

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[4] or seen in hospital clinics. Because some hospitals and emergency departments will close 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.

Best practice

1. though variations in service can be expected, the principles of good liaison are constant; regular 'coalface' contact with familiar and skilled clinical staff who can advise without more than a day's delay on the management of a whole range of predicaments faced in hospitals.

The best way to secure a liaison team's partnership with paediatrics is for the team to be co-located with, and funded and managed by, paediatric departments. Otherwise teams are liable to cuts or redeployment to other areas of community CAMHS, as is happening in many parts of the country now.

Out of hours availability of child and adolescent mental health/psychiatric staff is necessary to support hard pressed paediatric and nursing staff who are obliged to admit the vast majority all under 18s in crisis. There is no other resource as responsive and potentially capable as an NHS emergency department, nor will there ever be.

2. The key to liaison is a partnership from which all participants gain in knowledge and depth of skill in clinical practice. Many troubling cases can be reviewed in regular professional meetings *without being referred for mental health assessment or treatment*.

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[2] Woodgate M. & Garralda E. (2006), Paediatric Liaison Work by Child and Adolescent Mental Health Services. *Child and Adolescent Mental Health* 11: 19–24. doi: 10.1111/j.1475-3588.2005.00373.x

[3] see *National guidance on paediatric mental health* bit.ly/1EZ6G2d

[4] demand for which is currently increasing as many reports show, including national data BMJ 2008; 336 doi: http://dx.doi.org/10.1136/bmj.39462.375613.BE

3. A single mental health profession is not sufficient to manage the complexity or variety of clinical and consulting demands. Besides psychiatry, a liaison team will include a selection of other specialists drawn from psychology, psychotherapies and mental health nursing, possibly and preferably all of them. These staff all require specific experience and skills to work in hospitals, where the patients and their problems are mostly quite different from those seen in community CAMHS.

A significant proportion of complex paediatric presentations call for social work intervention. A well supported link with local – preferably co-located – social workers enhances seamless care in child health. Proposed integration of social services with health does not only benefit the elderly.

4. Collaboration and coordination between disciplines providing liaison services is essential. Neither patients nor paediatricians should be put in the position of having to work out which kind of specialist they need. *From the patient's point of view mental and physical problems are not separate*; nor should the services be. [appendix 2]

Benefits

1. Psychiatric emergencies involving any hospital patient under 18 – which can cause enormous pressure on paediatric and other hospital staff – must be dealt with promptly and effectively. Patients are otherwise left on wards or in emergency departments without mental health attention, blocking beds and breaching targets. Significant cost savings have been demonstrated in adult and elderly liaison services.[5]

With skilled multidisciplinary work, a short stay on a paediatric ward can successfully *avoid the need for a tier 4 (in-patient psychiatric) admission.*

2. The management of medically unexplained symptoms[6] (MUS) and of chronic/life limiting diseases (LTC) is greatly enhanced by co-located liaison teams, who help to shorten or reduce admissions and prevent unnecessary investigations, which can be expensive.[7]

[5] "A liaison service should be an integral part of the services provided by acute hospital trusts – trusts that have incorporated a liaison service have demonstrated much better cost effectiveness." www.rcpsych.ac.uk/pdf/JCP-MH%20liaison%20(march%202012).pdf ; www.centreformentalhealth.org.uk/pdfs/economic_evaluation.pdf

[6] Weisblatt E, Hindley P, Rask C. (2011) Medically unexplained symptoms in child and adolescents. In: F. Creed, P Henningsen, P Fink (Eds) *Medically Unexplained Symptoms, Somatisation and Bodily Distress: Developing Better Clinical Services.* Cambridge University Press.

[7] Dhroove G, Chogle A, Saps M.A (2010) Million-dollar Work-up for Abdominal Pain: Is It Worth It? *Journal of Pediatric Gastroenterology* 51:579–583. doi: 10.1097/MPG.0b013e3181de0639.

appendix 1

tasks of paediatric mental health liaison

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

2. medically unexplained symptoms at all ages from infancy to adolescence (failure to thrive and regulatory/feeding/attachment disorders of infancy, somatisation/conversion, 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, family/parental and sibling stress, reduction in hospital admissions, terminal care)

4. staff development and support (attendance at routine multidisciplinary meetings, joint clinical work in selected cases, ethics of palliative care, teaching specific courses, review after death of patients)

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

6. eating disorders

7. elimination disorders (resistant encopresis and enuresis)

8. post traumatic states (after serious burns, accidents and injuries, post major surgery eg transplants)

9. anxiety about procedures (needle phobia, imaging etc)

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

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

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

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

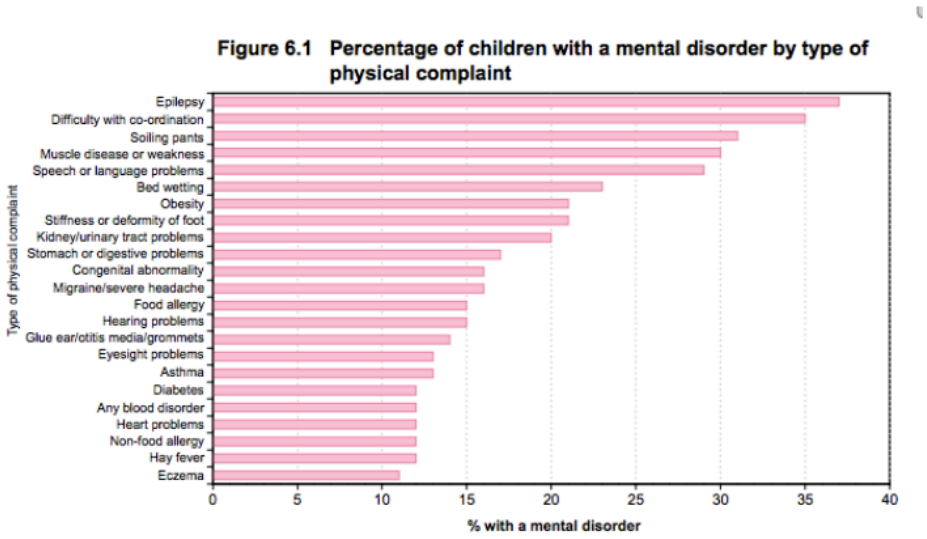
appendix 2

The overlap between chronic health conditions and mental disorder

Research data used to promote mental health in paediatrics relies on the fact that paediatric patients have higher rates of mental disorder, suggesting that these disorders are just other conditions needing treatment. So why can this treatment not be done somewhere else?

The answer is that in the patient's and family's experience the symptoms – whether unexplained or from an established disease – are *all one thing*. It makes no sense to the patient to be sent away for psychological help in another department or clinic.

Without co-location of mental health and paediatric care, clinical staff, patients and family have little chance of appreciating the intimate connections between mental life and physical disease.



from:, Meltzer H, Gatward R, Goodman R, Ford T. (2000) *Mental health of children and young people in Great Britain.* Office for National Statistics. London: The Stationery Office