The role of Paediatric Mental Health Liaison teams

I would like to thank the authors for producing the most significant (and accessible) paper that I have enjoyed since beginning my higher training in Child and Adolescent Psychiatry.

This is an essential ethnographic account of the inner mental states, characteristically undisclosed, of young people presenting in crisis to acute medical settings. I plan to share the paper widely amoungst colleagues in Emergency Medicine and Paediatrics, but it also makes for vital reading for other health professionals (paramedics, social workers and police) who will come into contact with this patient group in their respective, essential, lines of work.

The paper hints that the patients it describes are merely the tip of the iceberg. Most under 18s who deliberately self-harm do so in isolation and do not seek medical attention, precisely because of the degree of stigma and misunderstanding to which they can be exposed when they present to hospital.

Although deliberate self-harm is often impulsive, invariably there are significant and longstanding problems in the young person and his or her family. The instinctive "flight to health" under the circumstances described in this paper can be powerful, and young people may hide or minimise their distress in an attempt (conscious or otherwise) to leave the hospital. Some presentations (eg boxer's fractures in boys) are easily missed as self-harm events, because the young person in question will choose not to volunteer the context of the presentation.

What the paper does not directly address is the strategic means through which we can improve the experience of care for these young people.

Some argue that the acute hospital is not an appropriate setting to care for young people in psychological distress, but often they will need medical attention (bloods, stitches, scans etc) and they should be considered as much "Paediatric" as "Psychiatric" patients – their needs are no less deserving.

Admission to a paediatric ward (recommended by NICE guidelines but often not followed) is an entirely appropriate intervention, irrespective of immediate "medical" need. This demonstrates that the act is being taken seriously, that professionals recognise the severity of the symptoms and that the patient is being thought about, rather than 'disposed' of. Frequently, it is only the next day, in the safety of the paediatric environment (following consultations with family members and any already involved professionals) when the full social circumstances are made apparent, and disclosures are commonly made.

Dedicated Paediatric Mental Health Liaison (PMHL) teams, co-located with paediatrics in the acute setting, are sadly few and far between. Where they exist, they can provide a gold standard in integrated physical and mental healthcare, with rapid response times to A&E, including out-of-hours, when most such patients present. Assessments can be afforded sufficient time, and aside from quantifying risk, can be therapeutic events, making the child's prospective contact with community CAMHS a more approachable idea.

With the input of PMHL teams, admission to Tier 4 inpatient psychiatric services is rarely needed. Many patients are successfully assessed and managed on the paediatric ward for 24-48 hours, avoiding the need for a higher level of psychiatric care. These are therefore early intervention and cost saving interventions for the wider healthcare system.

In addition to the assessment and management of deliberate self-harm, PMHL teams perform a range of diverse roles in children of all ages from the neonate to older teens, including management of the psychological sequelae of chronic illness in children, medically unexplained symptoms, life-limiting illnesses, bereavement and perinatal mental health. The bulk of work in PMHL is in fact with such non-emergency cases. Liaison teams also help staff from allied disciplines to develop a more sophisticated understanding of such complex cases, by assisting in systemic reflection – often known as “work discussion”, or “psychosocial meetings”. The presence of a PMHL team is psychologically containing for paediatric colleagues as well as the patients. Such teams build confidence as well as resilience.

Too often, children and adolescents presenting with self-harm to hospitals without PMHL teams are left to wait for many hours to be assessed (a torturous and emotionally compounding experience, given the cognitive state they are often in as described so vividly in the paper). They may be reviewed by general adult psychiatrists who will perhaps lack the clinical acumen and confidence of a specialist in the field.

The rates of child and adolescent self-harm presentations to hospital are increasing year upon year. As promised new funding finds its way to the frontline of CAMHS services, it is to be hoped that a good amount of it is invested in Paediatric Mental Health Liaison Services which are a key intervention for this group of distressed and desperate young people.