

The liaison model

A guide to mental health services for children and adolescents

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This paper puts the case for accessible multidisciplinary mental health services for children and young people to managers, purchasers and GPs, in a framework of national and international statutes and guidance. The essential differences between the disciplines are explained, based on detailed advice from mental health colleagues in nursing, teaching, social work, psychology, child psychotherapy and child and adolescent psychiatry.

Significant mental health disorder can be expected in up to a quarter of the population of children and young people (Murphy *et al*, 1992). Although parents and teachers experience these problems daily they are too often unrecognised by the caring professions (Evans & Brown, 1994), with damaging (and expensive) consequences for the health of the nation as a whole. At present and for the foreseeable future, available resources can treat only a small proportion of the children and young people in need. There is an urgent need for greater flexibility, and expansion of mental health services for children (Black, 1992), not only to treat the referred patients and their families but also to advise and support primary ('front-line') professionals, in health, education, probation, social work and voluntary services. The liaison model specifies this provision. Currently mental health services for children and adolescents are commissioned on the basis of past provision, with little regard to need (Kurtz *et al*, 1994). Existing teams, especially those working from child guidance clinics, are threatened with disintegration, yet are overwhelmed with referrals, often resulting in long waiting lists, and demoralisation of staff.

Because they have widespread effects, child mental health problems cause anxiety in other individuals or agencies, yet may persist for months or years until a crisis forces a need for urgent help, often resulting in interagency

tensions around the referral itself. The difficulty is compounded by the fact that collectively we do not like to face the reality of children's mental pain, which therefore tends to remain secret and invisible, or shrouded in sentimentality (Trowell, 1991). In this vacuum, superficial and irrelevant solutions ("all he needs is more love/a short sharp shock", "she'll just grow out of it") abound.

The need for multidisciplinary teams

The causes and presentations of mental health disorder are multiple – biological, emotional and social – and disturbed and abused children usually require help from a number of disciplines, each focusing on different aspects, mental, physical, home, school, community etc. In spite of these complexities, the work of child and adolescent mental health services requires virtually no technology – it is essentially personal and labour-intensive. The common thread is the biographical development of the child in context, from conception to adulthood.

Services for mental and psychological disorder in children are therefore uniquely complex, requiring consultation and coordination across agency boundaries, with clear lines of authority and responsibility. Multidisciplinary teamwork, pioneered by child guidance clinics, is now widely recognised as the necessary basis of all good community mental health and child protection service (e.g. HMSO, 1988, 1989, and all child abuse reports (Reder *et al*, 1993)) and is actively being developed in work with adults in the care in the community programme (Department of Health, 1989). Ironically the reverse is the case in child mental health with many teams breaking up, especially through loss of social workers (Kurtz *et al*, 1994). Government policy is to promote

easily accessible multidisciplinary services (Department of Health, 1989) and as part of its *Health of the Nation* strategy, the Department of Health (1993) advises purchasers to protect specialist teams in child and adolescent mental health.

Funding and organisation: joint commissioning and lead provision

In the internal market the risks of disintegration may be increased but the problem is long standing. Since the beginnings of the national health service in the 1940s funding has never been properly addressed, with the result that the buck is continually passed round from one agency to another. Yet the 1993 Education Act and the 1986 Disabled Persons' Act require close liaison between local authority and mental health provisions for children. Under the 1989 Children Act social services departments are obliged to identify children in need (s17) – children with disabilities (which includes mental disorder), abused children and those suffering emotional deprivation – and to provide appropriate services for them in co-operation with health and education services (s27). Contracts for child and adolescent mental health services must reflect these needs: The NHS Management Executive states (1993) that “NHS authorities should work with social services departments to develop standards for psychological and psychiatric services for children and young people in residential care, and to ensure that health services required for the implementation of the Children Act 1989 are included in NHS contracts”. Joint commissioning – in which both local and health authorities share planning and costs of services – is greatly facilitated if the area served by a mental health team is coterminous with that of the local authority. Besides the local authorities, the primary allies of children's mental health services are the NHS provisions for sick and disabled children, in line with recommendations of the Court Report (HMSO, 1976) and the British Paediatric Association (1991) on integration of children's services. Whatever the future may hold for public services, the majority of disciplines in the child mental health team will remain health professionals. It is appropriate therefore that NHS providers should retain, or take, the managerial lead in

co-ordinating community mental health services for children and adolescents.

The liaison model

Prevention

The importance of mental health services in promoting the psychological health and well-being of children and adolescents is recognised by the government in its *Health of the Nation* strategy: “There is increasing evidence that early effective intervention in childhood and adolescence can be important in preventing adult mental ill-health” (HMSO, 1992, section F3). Early intervention can also reduce child abuse, later delinquency (Utting *et al.*, 1993) and ill health (psychosomatic disorder, addictions etc), but in order to reach children not yet in need of treatment, the service must be accessible to other workers in the community. Because the prevalence of child and adolescent mental disorder is so great, and specialist resources so few, it is necessary to have different levels of intervention: consultation/liaison and treatment. In the former the identified patient or family is not seen, and the task is to support professional colleagues already involved. The liaison model originates in mental health consultation to paediatric staff, where the staff develop working relationships over months and years. This can be an extremely efficient use of professional time. It does not interrupt the primary clinical task, but it requires some stability in the institution.

Consultation/liaison

Every day all children cross boundaries between caretakers – home, school and often other homes if their parents or guardians are at work. When children are mentally disordered or abused this network increases in complexity, to include other services – social workers (social services and educational), health visitors, doctors (hospital and community), speech therapists, foster carers, specialist teachers, probation, courts, etc. Breakdown of relationships between different agencies is a common occurrence when the problems are severe, as is well known from numerous inquiries into child abuse cases that have gone badly wrong (Reder *et al.*, 1993). To be effective, the primary care workers of these services should have accessible specialised backup, which is more likely to be

used successfully where the mental health team members are known and trusted in the community. Workers may be involved with families who do not need, or more seriously refuse to be seen by, mental health professionals, but they must be able to consult the team, by phone or in person for help and guidance (Evans & Brown, 1994). In some cases, particularly where anxiety is high, they should be able to make confidential enquiries about possible courses of action without naming the child or children concerned. The Department of Health obliges primary workers, particularly in social services, to identify such informal support: "Agencies should consider identifying a multi-disciplinary group of experienced professionals within each local authority who can be contacted for advice and who could contribute to multi-disciplinary training". (HMSO, 1988, p3)

Clinical intervention

This remains the core practice of team members, without which consultation and supervision skills would perish. Assessment interviews with the child and family can take place in the home, school, health centre or wherever is most helpful. Whatever the intervention other professionals, e.g. GP, health visitor, social worker, specialist teacher, may be involved in meetings with parents or families, or separately with the family's permission. Although labour-intensive, many interventions are short-term. Like the work with other professionals, they increase parents' understanding of children's development and of family processes, and strengthen their future functioning.

The child and adolescent mental health team

All members of the team have skills which they share. Foremost among these is the capacity to offer therapeutic or supportive consultations to others, parents and professionals (including other colleagues in the team) who have responsibility for children and young people. This is based on experience of clinical work and supervision of trainees. Co-operative work is particularly necessary in cases that generate high levels of anxiety, reducing the risk of burnout. Not all cases require more than one worker, but all the work benefits from discussions with team members not actively

involved – 'peer supervision'. The pattern of activity in such a team is closer to that of a modern general practice in a health centre than to a traditional out-patient department in a hospital.

Community child psychiatric nurses

These work mostly in the child and family's own home on regular planned visits. They may also be involved in the setting up and running of child and/or parent groups within the community, such as social skills, anxiety management. There are 391 nurses registered as qualified to work in child psychiatry, although not all do so.

Specialist teacher/educational therapists

They are trained to work with children who have deep-seated learning difficulties caused by emotional factors, who may be underachieving or disruptive at school. Many children seen are severely disturbed and deprived. The aim is to complement what is offered by the mainstream school with individual or group sessions. There are 170 educational therapists in England and Wales.

Social workers

Some are still called psychiatric social workers, and all have a particular role to play where child protection is an issue, where an in-depth understanding of the Children Act is needed, and where major moves require accommodation, care, fostering and/or adoption. The majority are employed by local authorities. Some have obtained training in family or other therapies often at their own expense.

Clinical child psychologists

Clinical psychologists are required to have a four year honours degree in academic and experimental psychology, two years experience as an assistant, followed by three or more years specialist clinical training to masters or doctoral level. Clinical child psychologists provide a broad range of clinical services for children, young people and their families, and consultation and training to professional colleagues. They perform complex assessments of cognitive abilities and emotional development, and may use structured psychological tests and observational techniques. Psychologists have particular

skills in formal monitoring, audit, needs assessment, evaluation of services, etc. There are 318 whole-time equivalent (WTE) clinical psychologists working with children and adolescents employed in health services in the UK.

Educational psychologists

There are approximately 800 educational psychologists in Britain, mostly employed by education authorities. They consult directly to teachers, parents and children in schools and may liaise closely with, and refer to, mental health teams. Specialist training follows a psychology degree and experience as schoolteachers. Much of their time is now taken up with statutory duties related to the Code of Practice and the 1993 Education Act, e.g. statements of educational need.

Child psychotherapists

Many come to this profession already armed with higher degrees (e.g. in psychology, nursing, or social work) and have intensive training in the identification and treatment of children's actual experiences of mental pain, severe disturbance, trauma, and loss. Even in the absence of obvious trauma, feelings and attitudes from past experience can be internalised, making the child inaccessible to other forms of help. Out-patient child and adolescent psychotherapy can replace the need for in-patient treatment. There are 174 full-time equivalent child psychotherapists employed in the NHS in the UK. This is far short of the recently recommended minimum of one WTE per 50,000 people, or the desirable level of one per 10,000.

Child and adolescent psychiatrists

Before training in this specialty it is necessary to be medically qualified and trained in general psychiatry. In addition many child psychiatrists have had experience in paediatrics or general practice. They are especially needed "when the presentation of a problem is complex or unusual, or when a wide range of aetiological factors are present, physical, emotional and social, or where there is doubt about the diagnosis" (Royal College of Psychiatrists, 1990). They may also specialise in assessment of children and families for the courts and consultation/liaison for paediatricians and other doctors. Occasionally medication may be prescribed. There are 392

consultant child and adolescent psychiatrists in England & Wales. The Royal College of Psychiatrists recommends an 'irreducible minimum' of 2, and a 'realistically desirable' level of 3, whole time equivalent consultants per 200,000 total population, to be multiplied by a factor of 1.6 in teaching districts. The actual figure is around half the desirable level.

Training

Both the clinical work of child and adolescent mental health services and the training for it are labour-intensive personal tasks, integral to a high quality service. Apart for junior medical grades (registrar and senior registrar) there is no statutory policy for training of child and adolescent mental health staff, which takes several years of postgraduate supervised practice. Besides salaries, trainees require space and senior staff supervision time, both of which must be costed. At the moment only psychiatric trainees have protected funding, held by Regional Deans. In addition to clinical work, consulting and training, all disciplines have research and academic roles, and are expected to keep up to date in their professions and to share findings with colleagues in others.

Administrative/secretarial staff

In multidisciplinary mental health teams, which usually include many part-time professional staff, the administrative/secretarial function is pivotal. Administrative and secretarial tasks in child mental health require high personal and managerial qualities that are not reflected in current public service rates of pay. Adequate funding and appropriate procedures for selection and appointment must be included in any plan for child and adolescent mental health services.

Conclusion

In a system where provision is guided by contracts for bits of service, there is an urgent need to recognise the quality and skills of child and adolescent mental health professionals. Overwhelmed by referrals and cuts, clinics are at risk of retreating behind waiting lists and losing contact with front-line colleagues. Yet the teams have unique knowledge that cannot be replaced by single-discipline services. The liaison model offers a

style of work that can make more immediate and intimate links with others who work for children, while at the same time preserving the cohesion and clinical skills of the mental health team.

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