

Medical education

Liaison psychiatry in a child development clinic

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The problem

Children with mental handicap and other developmental disorders are normally cared for by their families. This represents an important shift from the previous practice when psychiatrists in large hospitals for the mentally handicapped provided total care and organised medical support. The medical and educational needs of such children are now met by resources in the community. This has often meant that the psychiatric needs of mentally handicapped children and their families were ignored. In 1968 the Sheldon Working Party recommended that district handicap teams and child development clinics should provide a comprehensive diagnostic and therapeutic service for mentally handicapped children. The Court Report stated explicitly that psychiatric consultation should be readily available to children and families seen by such services.¹ Some new job descriptions require child and adolescent psychiatrists to accept this responsibility, yet many of them feel inexperienced in this area of clinical practice.

It has been recommended that child and adolescent psychiatrists in training 'must have the opportunity to participate in the work of a service to psychiatrically disturbed mentally handicapped children'.² In practice, arranging suitable experience has proved difficult. Although most children with mental handicaps and complex developmental disorders are known to their local child development clinic or district handicap team, and are the patients of the local developmental or community paediatrician, there is not often much liaison between developmental paediatricians and child psychiatrists. A senior registrar post in child and adolescent psychiatry was therefore established at St George's Hospital with special responsibility for children and adolescents with complex developmental delays and mental handicap (figure).

NATURE OF THE POST

The senior registrar works for two consultants—a

child psychiatrist and a consultant in the psychiatry of mental handicap—both of whom have a special interest in children with complex developmental disorders. This 15 months' job is part of the four year higher specialist training in child psychiatry at St George's Hospital. Supervision takes place at weekly meetings with each of the two responsible consultants (PDH and SCH) alternately, as well as during shared cases and consultations with them or the consultant paediatrician (DMH). The key component of the post is to liaise between the child and adolescent psychiatry department and the child development clinic at St George's. The latter is a well established multidisciplinary clinic staffed by a developmental paediatrician, a speech therapist, a social worker, an occupational therapist, and physiotherapists, who provide both a local service and a centre of expertise for referrals from a distance, usually for second opinions. Before the post was created there was already a good working relationship between the personnel in the child development clinic, the child and adolescent psychiatry services, and the department of mental handicap, with some consultations being offered and occasional referrals exchanged. There was, however, an overall feeling that they were three distinct departments, and the first holder of the post was asked to develop the liaison aspect of the service. He was able to become an active member of the child development clinic, attended regular staff meetings, offered staff support, saw patients with their therapists, and took on specific referrals for assessment or treatment.

The senior registrar became a member of a child liaison group, a multidisciplinary group from the mental handicap services that offered consultation and some direct intervention for mentally handicapped children. By his working in paediatric, child psychiatric, and mental handicap services, communication was made easier and inevitable misunderstandings were minimised. This is particularly important when a number of professionals work for

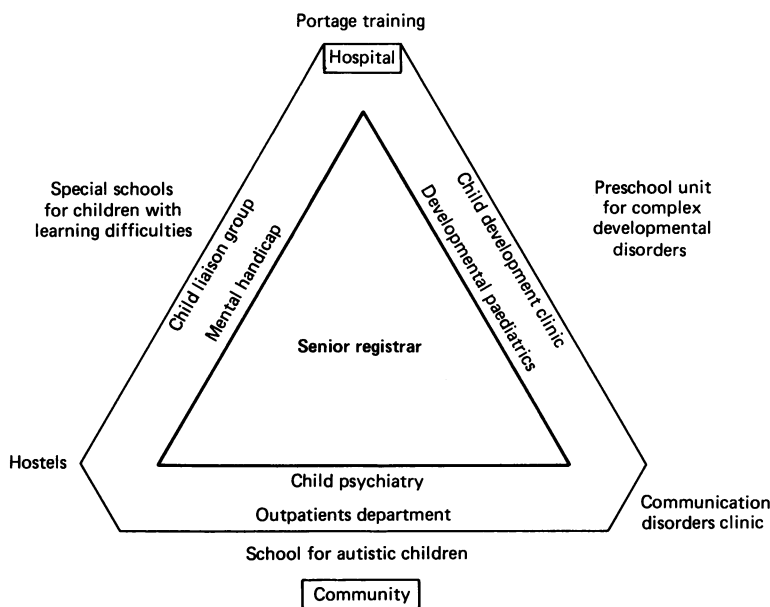


Figure The senior registrar's position in the services for childhood developmental disorders.

a long time with patients who are seriously developmentally disabled.

At the same time community links were established by the senior registrar providing regular consultation to local schools for children with severe learning difficulties, to a school for autistic children, and to a local day unit for preschool children with complex multiple developmental disorders. He joined the local Portage group* as a Portage visitor, helped supervise a support group, and subsequently ran training courses. Consultation was offered to social workers and staff in respite care hostels for children with mental handicap. All of this represented about half the week's work, the rest being spent in the department of child and adolescent psychiatry with both general referrals and those with developmental difficulties, together with general paediatric liaison, and personal training and research.

In the developmental disabilities component of the job the senior registrar was directly concerned with 53 cases as outlined below. He was also present in about twice that number of case discussions or combined interviews with the child development clinic staff, child liaison group, school consultations, Portage meetings, and consultations with social

workers. It is not possible to subdivide these figures further because the patients were usually being helped by a number of agencies. The success of the service depended on the senior registrar coordinating treatment or aiding communication between different hospital and community workers.

This paper focuses on the liaison with the child development clinic, illustrating the contribution of the psychiatrist in three principal ways.

- 1 The integration of a psychiatrist into general paediatric work depends on active participation particularly by making referrals easier, and by paying attention to staff support.
- 2 The psychiatrist's participation in assessing developmental disorder is valued because of his knowledge of the interaction of biological, psychological, and social influences on maturation. These are adjuncts to his colleagues' sophisticated understanding of neurological, motor and linguistic development.
- 3 The psychiatrist's therapeutic skills are versatile in that they can be used with children with developmental disorders and shared with other professionals.

Role of the psychiatrist in the child development clinic

MAKING REFERRAL EASIER

It is a well established principle of liaison psychiatry

*Portage: the Portage home visiting service for parents of children under 5 years with special needs to encourage home based teaching of appropriate developmental skills.³

that the immediate availability of a psychiatrist makes referral easier.⁴ Sensitivity to the appropriateness of a psychiatric referral is likely to be particularly pronounced in a child development clinic. Firstly, there is a particular concern that parents will misunderstand a paediatrician's request for psychiatric help as another indication of their failure.

Secondly, the long term relationship between the family and the clinic staff means that the referral cannot be handed over, but the psychiatrist must join in the work of the clinic and be seen to offer a continuity of care.

The senior registrar made himself easily available, attending clinic meetings, offered consultation to the relevant staff, or joined in interviews with the professionals and the family. Further clinical action hinged on the outcome of such meetings. One obvious consequence of this active liaison was a dramatic increase in the number of referrals for psychiatric assessment or treatment. Another was the development of a more positive view of psychiatric help, as was documented by a small independent survey of attitudes among the clinic staff.

ASSESSMENT

Bax suggested that developmental paediatrics and child psychiatry have large areas of theoretical interest in common, but often there is a failure to communicate about them.⁵ Our experience was that the psychiatrist was able to contribute to the assessment of the relative contribution of the biological, social, and psychological factors that are associated with developmental delay. An understanding of how individual and environmental influences interact helped to diminish any tendency of the clinic staff to assign the developmental delay to a single cause. Sometimes it was necessary to emphasise the effects of individual characteristics of children on their development. For example, a 3 year old with cerebral palsy showed severe separation anxiety with tantrums. The effects of the child's delayed motor development on the attachment process and an explanation of the concept helped to explain the behaviour, reduce parental tension, and establish a programme to encourage a gradual separation in a sensitive way. In addition the importance of adverse family or social factors needed assessing—as in the case of another child with cerebral palsy who was behaving oddly and whose mother had a manic depressive illness. Thirdly, knowledge of the possible mechanisms that underlie the association between developmental delay and psychiatric disorder was important. The disruptive behaviour of a child with severe language delay could be understood both in terms of the

child's frustration and in the ways in which he was particularly unrewarding for his adoptive parents.

The reactions of families to the birth and development of handicapped children have been well described.⁶ Understanding normal and abnormal reactions to the diagnosis was helpful, as in the case of a family who appeared unable to manage minor behavioural difficulties in their 5 year old who had severe learning difficulties. It was discovered that the family knew of a child who had had a successful operation for hydrocephalus and, while still in a stage of prolonged 'grief', they felt unable to deal with their child until he was likewise 'cured'. Acknowledgment of their difficulties freed the family so that they could take a positive approach and deal rapidly with the behaviour problems.

The child, family, and society may have inappropriate attitudes to disability that result in greater impairment. Appreciation of this was useful in the case of an 8 year old mentally handicapped girl who had recently arrived from Pakistan and was unmanageable at home. The senior registrar recognised that the family, privately, saw her as 'mad' and thought that she should be restrained. Discussion about the nature of her learning difficulties made for a more positive relationship with her parents, who then found her appropriate household tasks and valued her academic achievements.

As well as making these contributions, the psychiatrist learnt a great deal about assessment of neurological, motor, and linguistic disability. A 'communication disorders' clinic facilitated multidisciplinary assessment of children with complex language, social, intellectual, physical, and emotional disorders. Here the psychiatrist joined the paediatrician, clinical psychologist, and speech therapist in assessing the relative importance of a variety of developmental factors.

TREATMENT PROVISIONS

Skills normally deemed the province of psychiatry, though obviously not confined to it, were gradually established as areas of competence within which the senior registrar could contribute effectively.

- (a) *Consultation* was offered to clinic staff about the management of problems that previously would have been thought insufficiently serious by them to warrant a formal referral. For example, a therapist was concerned about the parents of a boy with severe language impairment who were unresponsive to his progress. The senior registrar suggested that the parents and the therapist should view the child through a one way screen to explore the parents' unhappiness and to work out how to encourage the child. As a result the parents

were less critical and the pace of his speech therapy accelerated.

- (b) *Counselling* of parents who were distressed or exhibited morbid attitudes to their child's disabilities is usually dealt with by medical social workers. The senior registrar offered alternative strategies or short term intensive treatment, as required. In one case a social worker had been giving long term support to a mother with an ambivalent attitude to her 6 year old boy and to the cause of his developmental delay. The senior registrar was asked to help with the boy's overactivity and enuresis, although it was felt that mother would be unable to cope with the necessary tasks. While carrying out a number of practical behavioural interventions, the senior registrar was able to explore the mother's guilt and anger, aspects of which she had previously been unable to discuss. This diminished her need to look for a new explanation for her child's problems as well as being able to develop a kinder but firmer style of parenting.
- (c) *Formal family treatment* was sometimes indicated, for example, in exploring marital and sibling tensions about the effects of dealing with the special needs of a developmentally delayed family member.
- (d) *Group treatment* is particularly appropriate in an area where sharing distress and coping strategies is especially helpful. A group was led by the senior registrar and a clinic social worker for parents of newly diagnosed mentally handicapped children where grief, anger, fears for the future, and practical information were shared.
- (e) *Individual psychotherapy* was used for some children and parents—for example, a quiet and compliant child with a severe expressive language disorder used individual sessions with the psychiatrist to play out his frustrations about not being able to communicate.
- (f) *Advice about psychotropic drug treatment* was sought, though this was not commonly implemented. Low dose neuroleptics such as haloperidol were usually only recommended in conjunction with behavioural treatment. The use of benzodiazepines was discouraged in view of their frequently disruptive effects on behaviour. A few children were given methylphenidate after assessment. Experience of the uses and psychological side effects of anticonvulsants were shared.
- (g) *Child care legislation and court work*—from time to time cases were seen in the child

development clinic that were the subject of legal proceedings. The senior registrar was a key figure in the assessment of parenting skills of a moderately mentally handicapped woman. A second case hinged on whether a mentally handicapped child might remain with his mother who had attempted a mercy killing shortly after hearing the diagnosis.

STAFF SUPPORT AND TRAINING

Perhaps the least obvious but most crucial indication of the success of the integration of the senior registrar into the clinic was the development of staff support. Professionals dealing with children's chronic developmental problems have long term relationships with patients and families that can be highly distressing. The staff in the child development clinic shared in the families' grief for the loss of a 'perfect' child after diagnosis, and in the awareness of the child's limitations. In some difficult cases therapists knowingly concentrated on individual work with children, thereby avoiding exposing themselves to the parents' distress. Increasingly, professionals turned to the senior registrar for verification or guidance about their response to psychological problems in the child or family.

The senior registrar was asked to teach a wide range of professional groups concerned with paediatrics, child psychiatry, and the adult mental handicap service. This included running a Portage course, teaching Portage visitors, and teaching staff from the child development clinic and the local nursery to help parents foster their children's developmental skills. Supervision was given to the local Portage service in behavioural techniques and coping with family distress. By visiting a family the skills of ongoing structured teaching were gained.

Conclusion

It is important to stress the two aspects of the liaison experience that have made this job a success. Firstly, the senior registrar was able to learn from the developmental approaches of the physiotherapists, occupational therapists, speech therapists, and paediatricians. There was a clear understanding that each discipline had skills to teach as well as to learn. Secondly, the senior registrar proved his worth by exercising his skills and by linking the three hospital services (paediatrics, child psychiatry, and mental handicap) with schools and nurseries in the community. The success of a community programme depends on the links between medical services, social services, and educational facilities. This complex multidisciplinary service and the chronic nature of the patients' developmental problems means that

communication between institutions is vital. The senior registrar helped to provide these links by visiting community facilities as well as by being part of the three services in the hospital.

The overlap in clinical skills among the various disciplines in child development services is well recognised. It is therefore worth considering whether this valuable training for a child psychiatrist is specifically the province of psychiatry. The discussion shows that many cases could be seen by other professionals, such as clinical psychologists or social workers. All such disciplines offered a service to the clinic at the time in question. Of the 53 referrals from child development clinics and related services, a quarter required a psychiatrist's special skills. These included, firstly, the assessment or treatment of parents and children with severe mental illness (including prescribing antidepressant drugs for a mother after the diagnosis of her child's disabilities, and neuroleptics for a schizophrenic adolescent). Secondly, medical training was essential in understanding the problems of children with severe organic disease—for example, a child with Rett's syndrome. Thirdly, appearing in court as an expert witness is particularly a medical responsibility. Fourthly, medical and psychiatric training provide the important theoretical knowledge that is necessary to make an adequate assessment of causative factors in complex developmental problems. Fifthly, in some circumstances a formal medical consultation is the usual approach, and is best received by concerned professionals—for

example, when a psychiatrist works with a medical officer in schools for children with special learning difficulties.

For the senior registrar himself the opportunities provided by working with families and professionals in a child development clinic are an ideal way of fulfilling the relevant requirements of the Royal College of Psychiatrists, as they apply to higher training in child and adolescent psychiatry. Paediatrics and child psychiatry overlap in a number of areas of clinical practice; this seems to be one area where they should also overlap in training.

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