

Paediatric Consult Liaison Service

The Christchurch Experience



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&

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Historical Trajectory



- Pre 1980 - community based child health/child guidance centre originally had a paediatric director
- 1980s - child psychiatry ward in general hospital co-located with paediatrics - informal links existed
- 1990s - no dedicated paediatric time - inpatient unit moved to geographically distant site - links unsatisfactory

- 2000 - 1 FTE dedicated to paediatrics - time used to provide MDT
 - allowed cross training & was not clinician dependent
 - based in psych clinic
 - clinicians attached to special areas ie diabetes, oncology, neurology
 - high no show rate 40% - low throughput 25/year - long wait times
 - fragmented and seen to be inaccessible

- 2002 - New psychiatrist - service changes
 - based in paediatric dept - closer working relations
 - 2 new cases weekly - 3/4 Wednesdays/month
 - regular consultation meetings
 - accessible with increased throughput - 60 cases/year - low no show rate - some specialty clinics continued

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- 2004 - Paediatric psychologist appointed - better service for pain management and procedural anxiety
 - new psychiatrist also appointed
 - late 2006 - current service format set up with increased input - 130-160 cases/year - access further improved - low no show rates - increased referrer satisfaction - mix of paediatric & psych clinic sessions - short waiting times

Purpose



- To provide consultation liaison services to the Department of Paediatrics to address psychological and psychiatric issues affecting paediatric patients and their families

Access



- Service available 0 - 18 years or school leaving age
- Clinics - 3 afternoon sessions - 1.5 new referral clinics + 1.5 for follow up
- Consultation liaison meeting with paediatric department - multidisciplinary - 1 hour monthly
- Psychological input to feeding clinic and oncology review meetings
- Paediatric ward consultations as required - may involve duty consultant psychiatrist at times
- Telephone/e-mail access as required and fast tracking!

Indications for Psychiatric Consultation

- Obvious emotional or behavioural disturbance in child
- Obvious family dysfunction
- Developmental delays or learning difficulties leading to significant psychological dysfunction or psychiatric disorder
- Frank psychiatric disorder in paediatric patients
- Unexplained physical symptoms or suspected somatoform disorder
- Symptoms in excess of those expected as a result of underlying physical illness
- Poorly controlled physical illness where psychosocial factors a significant contributor
- Diagnosis of fatal or seriously disabling physical illness
- Parental psychiatric disorder

Provided

- Focussed brief psychiatric assessment
- Brief treatment interventions - psychological, pharmacological
- Referral on to appropriate child or youth psychiatric services for more intensive intervention
- Discussion and timely advice on relevant psychological/psychiatric matters on formal and informal basis

Assessments 2006 - 2010



2006 - 2007 #124

2007 - 2008 # 125

2008 - 2009 #143

2009 - 3/2010 #80 (projected total = 160)

Service Trends 2006 - 2010



- Increased throughput
- Equal gender distribution
- Similar age distribution
- Increase in autistic spectrum referrals
- Increase in somatoform disorders i.e. chronic pain, chronic fatigue, conversion disorders
- Increase in eating disorder referrals
- Fewer ward consults
- More e-mail and phone consultation

Referrals (Sept 2006 - Sept 2007)



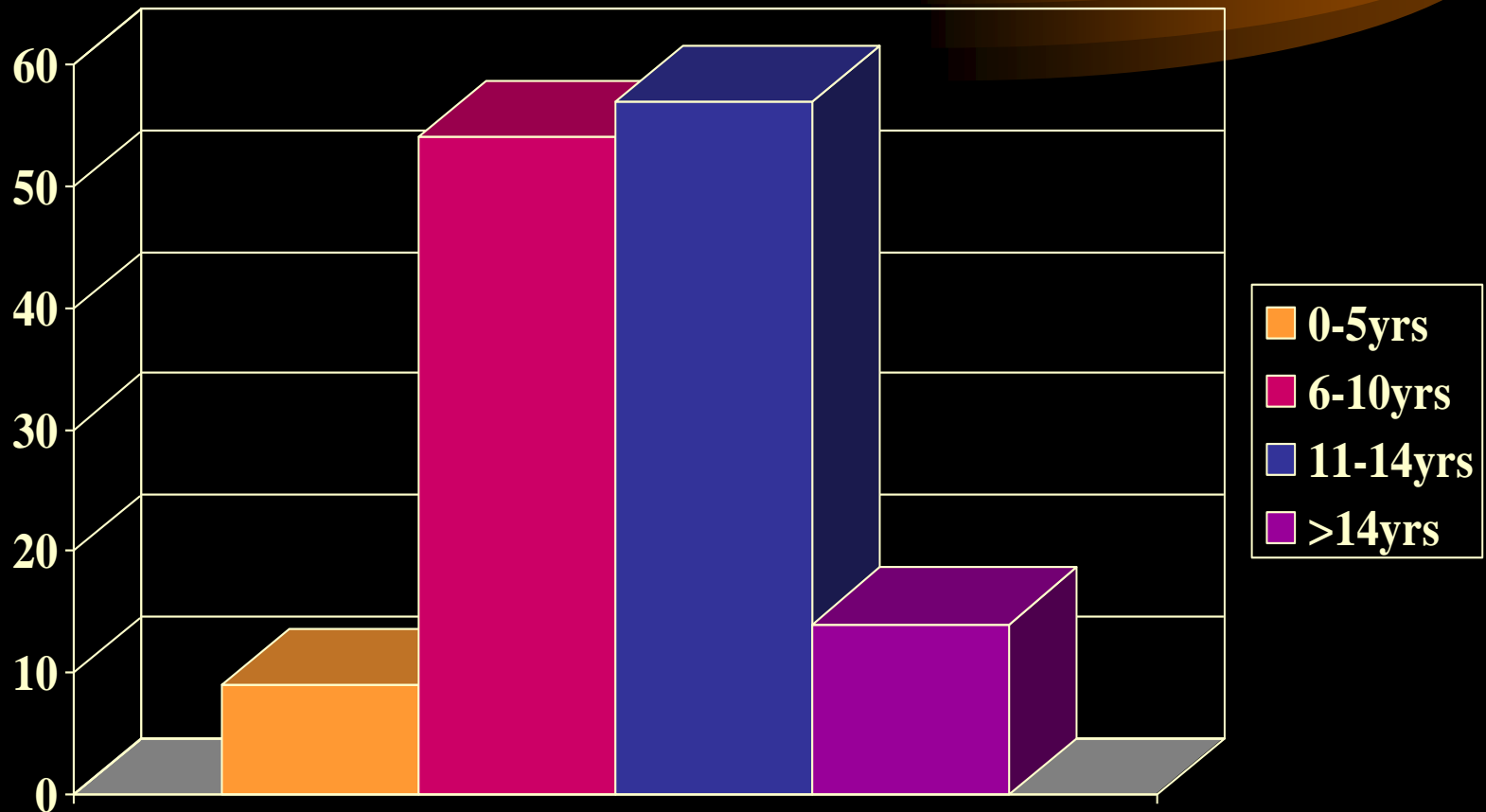
- Total # 134
- Attended - 124
- DNA - 10

Gender

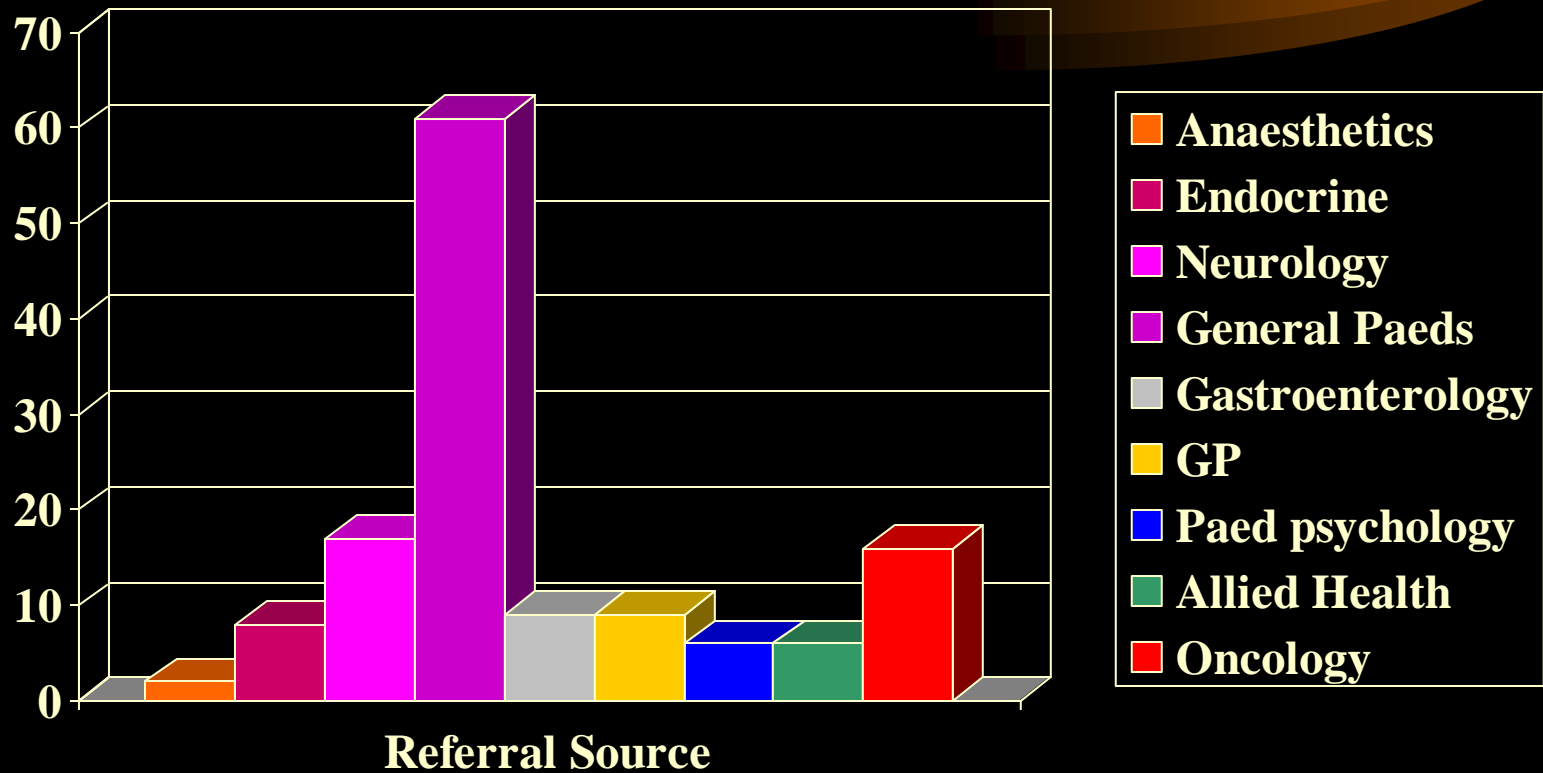


- Male - 66
- Female - 68

Age Range



Source of Referral



Diagnostic Groups

• Parent/child	37	• Mood d/o	14
• Adjustment d/o	27	• No psychiatric d/o	12
• PDD/Autism	22	• Behavioural d/o	9
• Somatoform d/o	20	• Encopresis/enuresis	9
• ADHD	20	• Feeding/eating d/o	6
• Anxiety d/o	18	• Tics/Tourettes	3
• Parent mental illness	15	• Psychosis/bipolar	2
• Intellectual Handicap	14		

Intervention

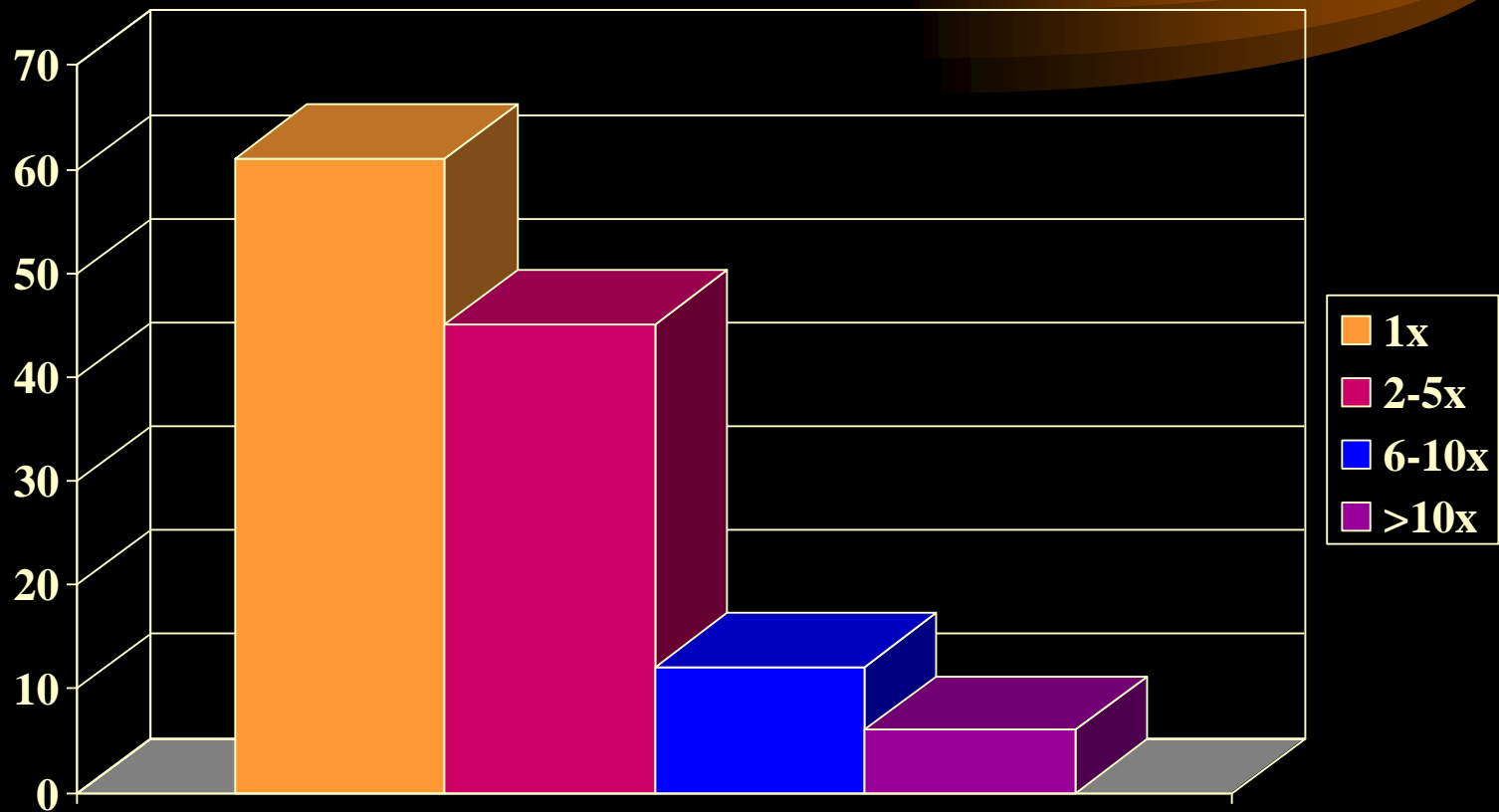
Referral to other services

- Inpatient Unit 6
- Child and Family 6
- Youth Specialty 6
- CYFS 5
- Intellectual Disability 4

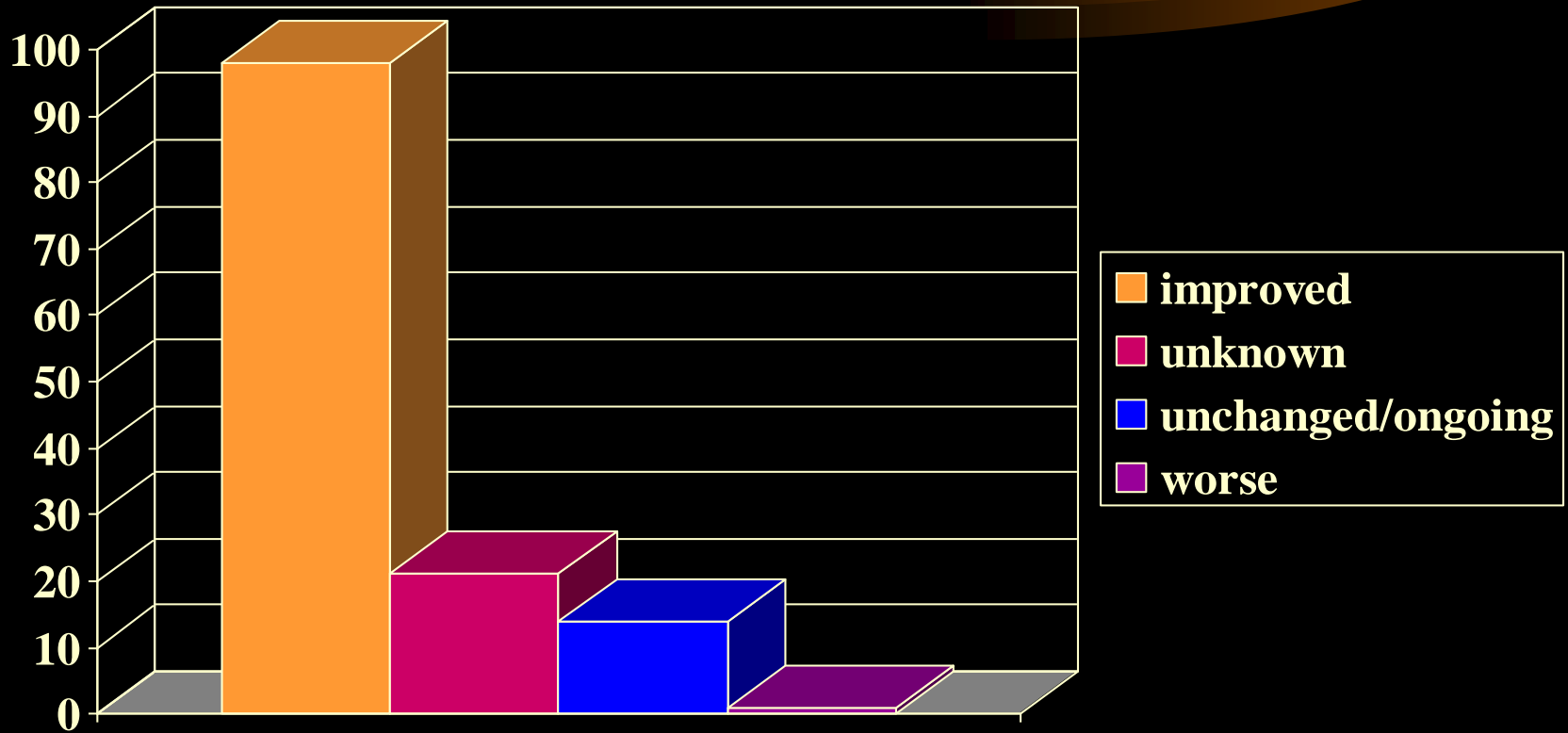
Treatment Interventions

- Assessment and advice only 61
- Parent education/behaviour mgmt 78
- Family/parent child therapy 24
- Medication 20
- Individual psychotherapy/CBT 15
- Environmental/school 4
- Psychodynamic 2

Treatment Intensity



Outcomes



Case vignette #1

- Female - now aged 17
- Seen FMHS age 8 - school refusal, behaviour problems
- Referred age 12 - abdo pain - controlling - angry - unwilling to engage - Mother has endometriosis and ? IBD
- Re-referred age 15 - chronic pain - low mood - anger outbursts - not attending school - refused to see male psychologist
- Gradual engagement - medication - encouraged course attendance
- 2006 relapsing - low mood - worsening pain - suicidal thoughts - seen by psychiatrist

Intervention

- Medication change - time limited therapeutic intervention - encouraging independence - support mother whose physical condition (chronic pain) relapsed
- Outcome - working at 2 jobs - joined gym - lost weight - found boyfriend - went to Australia on holiday - took family car without permission - mood euthymic - future oriented
- Observations - challenge of not buying into their hopeless, helpless passive aggressive viewpoint - took a long time to build trust - allowing Brian to cut to the chase!
- May have avoided becoming chronically impaired like her older sister

Case vignette #2

- Female age 6
- referred because of problems with anterograde continence enema (ACE) - had a congenital GI problem
- fighting daily clean-outs tooth and nail - screaming night-time battles with painful impacted faeces - parents stressed and exhausted having done this for years - continually give in also give in to her older brother - friends over every day - no time left - parents totally disempowered - patient seems remarkably well balanced but upset re procedures

Intervention

- We reframe difficulty as avoidance not trauma
- We sanction parents treating like any other aberrant behaviour - uncoupling the emotional baggage
- Parents given strategies - advice and support re timing and modus operandi - pre-warned of big battle first time (90 minutes actually)
- Outcome - much improved - significant behaviour shift - parents more relaxed - evident in family session - brother has friends 2x weekly - patient well rewarded and proud
- Observations - parents difficulty with emotional baggage - concerned re trauma - exhausted - patient always seemed less upset once procedure started - parents realised their ambivalence was major part of problem

Conclusions

- A consult liaison service can be run with limited resources
- Good relationships with paediatric team are essential
- Accessibility is important
- Interventions are for the most part brief
- Few patients referred on to other services
- Outcomes good in the main
- Appears to be a cost effective way to deliver service
- Further developments - expanded service proposal for new children's hospital being developed