FIONA SUBOTSKY AND ALASTAIR SANTHOUSE

Risky presentations

An audit of accident and emergency presentation of older children

AIMS AND METHOD

The aim was to review the assessment and management of the psychosocial risk (including substance misuse) of older children presenting to the accident and emergency department, with a view to making recommendations to improve services. The method used was to inspect casualty records of attendances over two weeks of 11–16-year-olds.

RESULTS

In no cases was any note made of whether substance misuse might have occurred. Cases of apparent psychosocial risk were, however, dealt with appropriately in the main.

The presentation of deliberate self-harm (especially overdoses) to accident and emergency departments and subsequent management by child and adolescent mental health services is comparatively well documented (Brent, 1997; Royal College of Psychiatrists, 1998). However, it is now recognised that other ‘accident presentations’ are commonly associated with a range of psychosocial difficulties and “health-risky behaviour” (Milgram, 1993; Rivara, 1995). For instance, in the US substance misuse (alcohol or drugs) has been reported as commonly associated in teenagers with presentations in accident and emergency departments or trauma admissions (e.g. Loiselle, 1993; Mannenbach, 1997; Spain, 1997). Recommendations have been made to use screening more and subsequently refer those positive to appropriate services (Maio, 1994; Buchfurer & Radecki, 1996).

In the UK drug and alcohol use and misuse has increased among young teenagers (Health Advisory Service, 1996; Miller & Plant, 1996; Coleman, 1997). A British inner city casualty audit (Connor, 1997) revealed that about 200 under-17s were brought in under the influence of alcohol in one year. Anecdotally, the inner city casualty department of the hospital in which the child psychiatry department is located reported an increase of children attending in intoxicated states. However, very few had ever been referred to child psychiatry.

The study

Casualty notes were collected on all 11- to 16-year-olds who had presented to the accident and emergency department during the course of two non-consecutive weeks. The entry made by the casualty officers was analysed and attenders were classified into three groups of risk:

(a) A low-risk group, in which the history was internally consistent and compatible with the injury sustained, for example, a child brought in by a teacher with a cut finger, after attempting to ‘slam-dunk’ a basketball into the hoop.

(b) A high-risk group, where either there was evidence of risk-taking behaviour, such as an overdose, or the history did not explain the injury.

(c) An uncertain-risk group, where there was insufficient history to judge risk (this included four youngsters who did not wait to be seen).

A note was made of whether the possibility of drug or alcohol misuse had been enquired about.

The high- and low-risk groups were then compared against the following parameters, which were recorded on the casualty card:

(a) who they were accompanied by (family member/ nobody or person other than family);

(b) gender;

(c) age;

(d) time of presentation (night/day);

(e) diagnosis (medical/trauma);

(f) outcome of attendance (discharged/admitted/ ‘other’).

Statistics

The χ² test was used to test associations of the binomial variables: risk, gender, who accompanied the patient, diagnosis, and outcome. The association of risk with night versus day was calculated using Fisher’s exact test. The association of risk with age was calculated using the Mann–Whitney U-test and further logistic regression analysis.

Findings

A total of 130 presentations of 11- to 16-year-olds to the accident and emergency department was recorded over the two weeks under study. In none of the 130 cases was a record made of an enquiry into the possibility of drug or alcohol use, regardless of the circumstances of the presentation. Of the 130, 71 (55%) were considered to be low-risk, 22 (17%) high-risk and 37 (28%) uncertain-risk (the last group was excluded from the statistical analysis).
Four parameters were not significantly associated with risk: age, gender, diagnosis and time of presentation. For outcome a high-risk individual was significantly less likely to be discharged, admitted for non-psychosocial reasons or followed up in the fracture clinic ($P=0.006$) (see Table 1). Of the 10 ‘other’ recorded for the high-risk group, four were sent back to the GP (one unwanted pregnancy, one self-harm, one medically unexplained shortness of breath and one child with recurrent fainting episodes). There were five referrals to child psychiatry, some of whom were admitted, all having harmed themselves in some way. One child was referred to casualty review, having punched through a window. It is of interest that four attenders said that they were pregnant or possibly pregnant.

Of the ‘other’ category in the low-risk group, five were referred back to the general practitioner (suture removal, chicken pox, conjunctivitis, asthma and laceration), two were referred to out-patients and one for casualty review, all with musculoskeletal injuries.

Of the ‘unascertained’ group four removed themselves before a full history or examination was taken. However, the presenting complaints were: one assault, one facial injury from a fight, one ‘inadvertently stabbed self’ and one rash — so that while the cases were not completely examined, risk looks high. Of these two were unaccompanied, two were with their mother.

When risk was compared with ‘accompanied by’, there was a significant result showing that risk was associated with not being accompanied by a family member on presentation to casualty ($P=0.006$), for example, a 15-year-old girl unaccompanied to casualty with a complaint of ‘Tippex in the eye’ raising the suspicion of solvent misuse (see Table 2).

**Comment**

It is important to identify psychosocial risk contributors to the presentation of youngsters to accident and emergency departments and to recognise where drugs or alcohol are part of this. At least 17% of the 130 presentations to casualty of 11- to 16-year-olds were high risk in terms of evidence of behaviour or inconsistency of the injury with the history. We found that another indicator of difference between the groups was whether or not the child was accompanied by a member of the family, so that this is important to record. That the difference between the groups was recognised in some way by staff was reflected in the differences of outcome between high-risk and low-risk groups, with a higher proportion of the former being referred on to child psychiatry usually for deliberate self-harm or to the general practitioner. Only one case of self-harm out of six was not referred to child psychiatry. While there was no evidence in the casualty note system of referral on to social services there is a back-up notes review system provided by a liaison health visitor.

The specific problems of drugs and alcohol are still being overlooked despite evidence suggesting that there is increasing use of drugs and alcohol in the young, and that there is a strong likelihood of associated presentations in casualty. There may be a number of reasons for this. First of all, there may be pressures of time and that substance misuse is not even thought about. Second, if it is thought about and asked, what should the casualty doctor do with this information? If every child who experiments with drugs is referred, the child psychiatry services would be quickly swamped. Similarly, this creates a problem for the child psychiatry services, who do not necessarily have the expertise and experience in dealing with children with genuine addictions, or access to specialist services in the way adult psychiatrists do. Yet a casualty ‘crisis’ could be a good opportunity to pick up and intervene with those with substance misuse problems.

As the next stage of the audit we fed back the findings to a variety of groups — accident and emergency, the child psychiatry department, paediatricians. We developed brief advisory guidelines for casualty staff on how to assess and appropriately refer children who may have misused drugs or alcohol, and we have also produced a leaflet for young people and parents advising them about sources of help if there are concerns about the use of drugs or alcohol. Meanwhile, discussions with the addictions directorate and the local purchaser are ongoing and we hope to be able to provide better services for the target group of young people who misuse drugs and alcohol and have associated psychosocial problems.

### Table 1. Risk by outcome

<table>
<thead>
<tr>
<th>Risk level</th>
<th>Discharged</th>
<th>Fracture clinic</th>
<th>Non-psychosocial admission</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk</td>
<td>8 (36.3%)</td>
<td>1 (4.5%)</td>
<td>3 (13.6%)</td>
<td>10 (45.5%)</td>
<td>22</td>
</tr>
<tr>
<td>Low risk</td>
<td>43 (61.4%)</td>
<td>5 (7.1%)</td>
<td>14 (20%)</td>
<td>8 (11.4%)</td>
<td>70</td>
</tr>
</tbody>
</table>

### Table 2. Risk by “accompanied by”

<table>
<thead>
<tr>
<th>Risk level</th>
<th>Family member</th>
<th>Non-family member/ nobody</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-risk</td>
<td>12 (54.5%)</td>
<td>10 (45.5%)</td>
<td>22</td>
</tr>
<tr>
<td>Low-risk</td>
<td>59 (83.1%)</td>
<td>12 (16.9%)</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>71 (76.3%)</td>
<td>22 (23.7%)</td>
<td>93</td>
</tr>
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</table>
Acknowledgements
We are grateful for the goodwill and cooperation from the staff in accident and emergency at King’s College Hospital, London, especially Dr Ruth Brown, consultant. We would also like to thank Dr Clive Holmes for statistical advice.

References


MANNENBACH, M. S., HARGARTEN, S. W., & PHelan, M. B. (1997) Alcohol use among injured patients aged 12 to 18 years. Academic Emergency Medicine, 4, 40–44.


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Adult psychotherapy and child and family psychiatry
Ten years of working together for parents and infants

AIMS AND METHODS
This paper describes a 10-year alliance between an adult psychotherapy service and a child and adolescent mental health service to bring psychotherapeutically-informed help to families in difficulties early in the lives of their children.

RESULTS
It outlines staff training, the development of the unit into a significant training resource, the unit’s underlying philosophy, its therapies and the key inter-relationships between teams and with health visitors to enable mutual teaming and the rapid access of families to assessment and treatment of the parent–child relationship.

CLINICAL IMPLICATIONS
Funding, future plans and the preventive and economic implications of such work are mentioned.

Psychotherapy departments have been urged to develop ways of working that render assessment processes more efficient and make psychological therapies available more widely and more equitably, while targeting those in greatest need (National Health Service Executive, 1996; Holmes, 1998). The Government recognises troubled families with young children as such a target (Home Office, 1998).

Since 1989, with the aim of secondary prevention, the psychotherapy team and children’s mental health workers in Runcorn, Widnes and adjacent parts of rural Cheshire have allied to bring psychotherapeutically-informed help to families.

Conception
The alliance began when we were working as a general psychiatrist with special interest in psychotherapy, a child psychiatrist and nursing sister of an adult psychiatric admission ward. Joint work with a young mother and her toddler had shown us vividly how the mother’s severe psychopathology impaired her capacities to foster her child’s development and how little we could influence that process. We began to envisage a service able to help such families before the children’s development became irreparably affected.

A community-based team would draw on expertise from psychotherapy and child and family psychiatry to target two groups: (a) families having difficulties early in their children’s lives, including those where the mother was depressed postnatally; and (b) more chaotic families whose entrenched difficulties were inadequately addressed by existing services. Rapid access, outreach and joint working with other professionals would let the team benefit from others’ expertise and spread psychotherapeutically-informed help most widely.

Birth
In 1989 an outdated hospital closed, releasing monies for community psychiatry and staff re-training. We
received funding, including outreach and training budgets and the psychotherapy family unit (PFU) was established as a nurse-led team of three experienced adult mental health workers, supported by sessional input from both consultants. Our present complement is three nurses, one occupational therapist and a nursery nurse. Managerially, PFU is part of the adult services, but crucially, it has developed and functions between the child and adolescent mental health service (CAMHS) and the adult psychotherapy team. One building houses the three teams.

**Training and development – continuous processes**

At first the PFU therapists learned from the child and family workers and the two psychotherapists through much joint work and supervision: such learning is now mutual. Child psychiatry has taught us systemic family work, assessment of families and attachments, networking skills and awareness of child protection issues. Our psychiatric training helps us detect mental illness. Psychoanalytical psychotherapy teaches attention to boundaries, meaning, projective processes, transference and countertransference and helps us bear the impact of our work, including engaging with intense feelings in ourselves and others. To facilitate the application of psychotherapeutic skills in the PFU work, each PFU therapist always has two cases in supervised psychotherapy for the adult psychotherapy team. All therapists have gained introductory trainings in group analysis and family therapy. One has qualified in psychoanalytic psychotherapy. One consultant obtained supervised experience in the Tavistock Clinic’s Under Five’s Service (Hopkins, 1992). The other trained in the Parent/Child game (Forehand & McMahon, 1981). As we learn, the PFU evolves, anchored by certain principles.

**Core principles**

The PFU focuses on the parent–child relationship, using psychoanalytical, systemic and cognitive approaches within time-limited contracts. We aim to keep both parent and child in mind: doing so requires discipline, but repays effort.

The help that families need and can use varies and timing that help is important. Several courses of care may be needed for a family’s various components — family, sexual couple, parent(s), parent–child relationship, individual(s), child(ren). Each course of care is provided by the most appropriate team. The process of deciding among the teams and with the family which elements of the family need and wish help, in which order and from which team is valuable. It clarifies each team’s responsibilities, helps address how family members’ needs are negotiated and emphasises the need for appropriate boundaries around the family’s various components and certain subject matter. Where these discussions become heated and agreement difficult this can reflect and illuminate processes in the family. Understanding this helps us tolerate our disagreements.

Where we consider a child may be at risk (not necessarily one within the immediate family), we address this and our responsibilities under the Children Act 1989 with the relevant adult(s). If uncertain about such matters, we seek the advice of CAMHS’s Social Worker, preserving case anonymity until our responsibilities become clear. When the Act was introduced, we felt anxious and resentful at its intrusion into our therapeutic relationships. We have learned that when concerns for children’s safety are aroused in us, similar concerns exist in the parent(s). Discussion thereof, although never easy, mostly affords relief. Rapport usually survives, or can be recovered.

Even if only mother and child attend, we ensure father and any partner are remembered in the work. (It happens that all the PFU staff are female. The male colleagues who join us for work experience show us the value of a male perspective and presence and, fortunately, that our current gender skew does not fundamentally affect the PFU’s work.)

The PFU encourages consultation early in the life of a family’s children. Using home visits when appropriate, we ensure rapid access to assessment and brief focal work. By remaining quietly enthusiastic and readily available in whatever way is useful, we maintain strong links with colleagues in primary, secondary, tertiary care and social services (Daws, 1999).

**The PFU’s therapies**

Early parent–child difficulties are typically postnatal depression, bonding, sleeping, feeding, crying and oppositional behaviour. Fundamental to our work is our close collaboration with health visitors to alleviate distress and prevent developmental distortion by promoting the early detection and treatment of postnatal depression: the experimental attachment of a liaison health visitor to CAMHS has enhanced this alliance. The local health centre-based support groups for postnatally depressed women are each conducted jointly by a health visitor and a PFU therapist; their location facilitates informal consultation by primary care professionals. At follow-up, some women accept further help from the three teams for themselves, their partnerships or their families.

For early relationship difficulties, we also offer two brief focal therapies, one psychoanalytical, the other cognitive–behavioural. Our Brief Parent–Infant Clinic (BPI) is the core of our rapid-access focal work. Parents and children are offered up to six sessions for psychoanalytically-informed thinking about their situation. Our foci are meanings, feelings and connections between the problems and family members’ internal worlds. Often we find un-mourned losses, painful struggles with parental ambivalence and un-metabolised difficulties in the ordinary transitions to becoming a family (Hopkins, 1992). The six-session cognitive–behavioural Parent/Child game helps parents acquire greater skill and sensitivity in playing with
their children and in managing a child’s difficult behaviour. We may use the focal treatments consecutively, their order determined by the parents’ readiness. Thereafter, some mothers proceed to an analytical mothers’ group.

Families with more entrenched difficulties and sufficient motivation may join a family day therapeutic community programme, which centres on a family meal and includes relationship play (Binney et al, 1994), an analytical mothers’ group and video-aided work on live parent—child interaction. The PFU also provides a marital and family therapy clinic for the adult population.

Linking the three teams

Tensions are inevitable between three multi-disciplinary teams when one is orientated to children, one to the parent—child relationship, one to adults. Several factors help keep these tensions creative and our working relationships healthy.

Important always, but especially during times of change, are the understanding of each other’s work and respect for each other’s professional expertise gained from joint working throughout our shared development. Clear boundaries are needed around each team with clear guidelines defining appropriate work for each, cross referrals and inter-team consultation. The PFU’s adult mental health origins make one guideline central — if you wonder whether CAMHS could or should help, ask them now.

The composition of the various weekly intake meetings is crucial. A PFU therapist attends the intake meetings of CAMHS and adult psychotherapy. The child psychiatrist has a key role in PFU’s intake meeting, where family referrals and assessments are discussed. She also attends the BPI supervision meeting, which the consultant psychotherapist leads. These arrangements have many advantages.

On receipt of an adult psychotherapy referral, we may suspect that the individual’s difficulties have originated in the transition to parenthood, that a child may be at risk or that family therapy might be more appropriate. Then a prompt home visit by a PFU therapist, possibly with a CAMHS worker, may clarify matters quickly. Having this option is a great boon.

The presence of our several perspectives in each meeting enriches our understanding of referred cases and our plans for work with them. Much background information becomes available, even concerning referrals in a parent’s own childhood and can help anticipate difficulties in engaging patients. Multiple referrals are short-circuited. The most appropriate first assessment can be planned, sometimes a joint one. We have more flexibility to help parents who have presented through their children engage in work on their own difficulties.

Funding, research and future hopes

Our funding is within Halton General Hospital Trust’s block contract for mental health and is roughly half the psychotherapy budget, augmented by one consultant session from the Halton Community Trust’s budget. If monies became available, we would appoint a child psychotherapist, then a qualified family therapist. Research projects are planned on our Parent/Child game and BPI work. We hope the links developing between the Trusts and Social Services may eventually permit a coordinated under-five’s service.

Teaching resource

The PFU has become a valued teaching resource. The PFU members teach a family work module on the University of Liverpool’s MSc in Occupational Therapy, train health visitors for postnatal depression listening visits and train colleagues in the Parent/Child game. Fellow professionals who join us for supervised experience, including specialist registrars in psychotherapy and child psychiatry, find that BPI work has great impact on their practice, teaching them the value for families and professionals of keeping both parent and child in mind. They experience the intense and conflicting raw emotions in early relationships, the demands these place on parents and the speed with which early help can often achieve significant improvement.

Working with disturbed young people and their families, we often find their early histories suggest BPI work might have helped. Balberne (1999a,b) has outlined the huge financial costs to society of failing to intervene early to improve family life, infant mental health and development. He describes the well-researched early-intervention services which are an established part of American provision. We hope this brief account helps promote interest in such work in Britain.

Acknowledgement

Dilys Dawes, Consultant Child Psychotherapist, Under Five’s Service, The Tavistock Clinic gave helpful advice on an earlier draft of this paper, as she has on the PFU’s development.

References


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Adult psychotherapy and child and family psychiatry: Ten years of working together for parents and infants
Sheena Pollet, Margaret Bamforth and Gloria Collins
Access the most recent version at DOI: 10.1192/pb.24.4.139

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