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# Experience of the visitor: on-call child and adolescent psychiatric consultation to hospital colleagues

How can the on-call child and adolescent psychiatrist operate most effectively within an often rigid system to enable the most appropriate outcomes for young people presenting to emergency hospital services?

In our locality, child and adolescent psychiatry has no hospital beds of its own but provides 'consultation' to the on-call hospital paediatricians and adult psychiatrists. Several hospitals are covered, each with different protocols. Consultant child and adolescent psychiatrists from the respective trusts supervise the work of the specialist registrar on call.

Each hospital emergency department has protocols relating to quality standards, as well as recent service developments. In all the hospitals covered, the standard dictating a maximum wait of 4 h for any patient awaiting transfer out of the emergency department has affected practice and has increased pressure on the on-call teams. Provision of comprehensive child and adolescent mental health services (CAMHS) will soon include the provision of crisis resolution home teams for those over 16 years and early intervention teams for those over 14 years. More teams will be in the system and thus there will be more protocols. Will this be a problem?

Protocols are primarily designed to protect patients from poor medical practice. However, they are used increasingly to protect hard-pressed and under-resourced teams from overwhelming demand (V.Z. Roberts, personal communication). Is it any surprise, therefore, that the front-line staff in the emergency department and paediatric and adult psychiatric services often protect themselves from the complex demands presented by 15- to 18-year-old adolescents? Biological and foster families and education and social services departments have already done the same. For these are the young people who present too great a demand on the system; they are end results of chronic abuse or neglect throughout childhood, have a string of failed placements in their wake and often have the beginnings of careers in the penal system or of adult personality disorder. The wish to avoid taking responsibility for this group of patients is 'contagious' and for these young people the effects of being unwanted are cumulative.

The child and adolescent psychiatrist dealing with these patients seems to get caught up in the same process of being 'shut-out'. In the hospitals we cover, we routinely deal with bed and site managers who maintain that they have no responsibility for assisting us in finding a bed for an adolescent with mental health problems. Would this attitude be tolerated with any other patient group or by any other group of doctors?

How, then, can the child and adolescent psychiatrist work through this self-protective organisational functioning, a state driven both consciously and unconsciously – the conscious state driven by the need to meet quality standards and the unconscious by the need to protect oneself/the team/the service against difficult engagement with a young person who has already been poorly served by and, possibly, damaged other systems? If one also considers the personality and power-based stand-offs that often exist between senior staff across disciplines (e.g. between paediatrics and child psychiatry, or between adult and child mental health services), the scene is set for rigidly maintained professional boundaries. As Menzies (1988) so articulately described, each professional healthcare group has its own way of guarding against feeling overwhelmed by the demands and needs of patients. Sticking to protocols and other forms of bureaucracy can be understood as serving such a protective function. However, inflexible inter-departmental and inter-trust boundary-keeping may militate against the best outcome for the patient. It is for this reason that the child and adolescent psychiatrist may spend disproportionately long periods in the negotiation phase of their work.

## The visitor's perspective

As a professional who is only intermittently involved with the hospital system, the child and adolescent psychiatrist functions as a visitor whose critical capacities can help the young person. Being able to reflect on the defensive strategies at work, trying to think past the arguments about protocols and engaging with fellow professionals in a 'we', rather than 'you or me', way are vital. Combining these approaches allows the focus of work to return to the patient and reduces the chance of staff feeling ill-used or exploited by each other. A child and adolescent



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psychiatrist able to tolerate and think about the feelings engendered in hospital staff by highly disturbed and disturbing young people can prevent a re-enactment of abuse, parental conflict and rejection.

A different 'space' can be created, such that protective mechanisms employed by different groups do not result in an unproductive impasse between, for example, the paediatric team and the child and adolescent psychiatrist (Menzies, 1988). Sensitive communication is required. Negotiation is needed not only with the young person but also the nursing and medical/psychiatric staff. For example, paediatric staff, committed to and protected by a particular protocol, require explanations about why a young person might be better placed on their ward rather than the adult ward. The idea of 'doing right' rather than 'being right' needs to be encouraged.

Being called in at night as the emergency specialist reinforces the role of the 'expert doer' learned in medical training. Giving this up is not easy. However, if making recommendations from this position fails to achieve an appropriate placement for the young person, the child and adolescent psychiatrist can consider stepping out of the 'expert doer' role and use instead their visitor's position. Describing management of a similar patient from another context can be helpful in encouraging others to approach the problem in a different way, as illustrated in the vignette below.

> During a weekend, Dr A, the on-call child and adolescent specialist registrar, was asked by adult psychiatry to review a young woman aged 17 years who had been admitted to the emergency admissions ward. The patient had taken an overdose of paracetamol and did not want to remain in hospital, despite appearing to be in a disturbed mental state. The patient presented as a very young 17-year-old, with a physically slight frame, who was confused by probable early psychotic phenomena. In the view of Dr A, placement on the adult ward would be inappropriate given the patient's build and level of emotional immaturity. A significant amount of time was therefore spent talking with senior paediatric medical and nursing colleagues about positive experiences at another hospital where the paediatric/adult age cut-off was higher. This, in combination with a clear formulation of the young woman's mental health needs and risk staus, led to the young woman being placed on the paediatric ward under a paediatric consultant, with child and adolescent psychiatric liaison. Here, the vulnerable adolescent, housed in a young adult body, was able be cared for more appropriately than on the adult ward, where she would have been in the company of older adults with significant psychosis.

Although playing a useful role, being a visitor can be quite a lonely business. Specialist registrars in child and adolescent psychiatry, without on-site seniors, can feel vulnerable in comparison to their emergency department, paediatric and psychiatry colleagues. Their stand-alone status can also make them easy scapegoats when situations with adolescent mental health patients go wrong (including breaches of the 4-h maximum wait). Equally, their identity as the medical group dealing with young people who present complex and challenging pathology means that they are often expected by colleagues to assume responsibility for that which is inconvenient or unbearable. These problems are illustrated by the second vignette.

> Dr B was contacted by the paediatric team about a 15-year-old boy, C, who had been brought to hospital by his aunt just before midnight on a weekday. The aunt reported that her nephew had been physically and sexually threatening towards her that day. C was obviously experiencing psychotic symptoms, and had a history of admission to an adolescent in-patient unit during the preceding year. He had no insight, did not agree to staying in hospital and was clearly unsuitable for admission to the paediatric ward. The area had no crisis resolution team, so Dr B started trying to negotiate a bed for C prior to performing a section. No NHS bed was available and since C , like many such patients, was not resident at an address in the local area, obtaining funding for a private adolescent bed was difficult. C's area child and adolescent mental health on-call service argued that they were not the responsible team.

Unlike her paediatric colleagues, Dr B was the sole representative of her team and was therefore the team member towards whom all the anxiety about breaching the 4-h wait was directed. The patient, having been referred to child psychiatry, was no longer seen as part of a shared project with the emergency department or paediatrics. Add to this the previously cited issue of non-cooperation by bed and site managers, the worry that the patient would leave the emergency department before a transfer bed could be found, and the fact that C's local child mental health services were being less than helpful, and the reader can imagine the sense of isolation felt by the on-call child and adolescent specialist registrar.

As the vignette demonstrates, authority is an issue for the visitor. With the on-call consultant also an outsider in the system (generally employed by a different trust), lack of site-related authority reduces the potency with which the on-call child and adolescent psychiatry team can challenge accepted practice (e.g. the non-involvement of the site manager in finding a bed). The example also highlights the fact that the disinclination to get involved with on-call adolescent mental health patients is not confined to emergency department, paediatric and adult psychiatry services. Child and adolescent psychiatry services themselves are not immune to falling back on protocol and bureaucracy.

## Promoting joint work across formal boundaries

The current organisation in hospitals is one riven with artificial splits, such as age cut-offs and protocols. Patients entering the system become objects to be processed; their age or presentation either meets the entry requirements for service X, Y or Z, or it does not. However, the kind of young people requiring on-call consultation from child and adolescent psychiatry present the hospital with a constellation of complex issues which do not necessarily fit neatly into predetermined categories. For example, their developmental stage inevitably brings to the fore the question: when does a child really become an adult? Age cut-offs promulgate the notion that all 16-year-olds, or all 17-year-olds, are of equal physical and emotional maturity. The reality is, of course,



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quite different. It is the task of the child and adolescent psychiatrist to encourage collaborative thinking about the particular situation of the individual patient. This can be done by engaging with the referring team as a visiting or temporary team member. In this way, a task-specific inter-disciplinary or inter-agency unit can be created to address the young person's various needs. This kind of working achieves a person-relevant outcome rather than a service-based statistic.

## Declaration of interest

None.

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