



## LIAISON PSYCHIATRIC NURSING: MODELS AND ROLES IN MATERNAL AND CHILD HEALTH NURSING

**Akoijam Mamata  
Devi**

PhD Scholar, Shri JJT University, Jhunjhunu, Rajasthan  
Professor, Faculty of Nursing, SGT University, Gurugram

### KEYWORDS :

#### INTRODUCTION:

Liaison psychiatry is the branch of mental health that specializes in the interface between different medical specialties and mental health team, usually taking place in a hospital or medical setting. It also known as consultative psychiatry or consultation-liaison psychiatry (also, psychosomatic medicine). Consults means when the primary care team has questions about a patient's mental health, or how that patient's mental health is affecting his or her care and treatment. The Mental Health team works as a "liaison" between the medical team and the patient. Issues that happen include ability to consent to treatment, conflicts with the primary care team, and the intersection of problems in both physical and mental health, as well as client who may report physical symptoms as a result of a psychological disorder.

#### MATERNAL MENTAL HEALTH:

Maternal mental ill-health has a long-term effect on maternal wellbeing, family relationships and the mental health, social adjustment and attachment of the child during the first critical years of life, therefore prevention, early diagnosis and intervention is vital.

The mental health of the mother has a significant effect on the health of her children during pregnancy but also throughout the child's life with a significant influence on foetal and early brain development. Poverty and low socioeconomic status are associated with poor psychological and physical health when women come to pregnancy and are determinants of pregnancy outcome bringing about social disparities in pregnancy. Mental health problems in pregnancy and the postnatal period are associated with adverse outcomes for the foetus and the baby as well as for the woman herself; for example, severe depression is associated with an increased risk of lower birth weight and premature babies, particularly for families affected by socioeconomic deprivation, self-harm and suicide. Perinatal mental illness is complex and covers a range of conditions of varying severity including post-partum psychosis, mental ill-health and depression, perinatal obsessive compulsive disorders and anxiety.

#### PERINATAL MENTAL HEALTH PROBLEMS

Perinatal mental health problems related studied in more than 90% of high income countries (HICs), whereas information is available only for 10% of low and middle income countries (LMICs). Pregnant women and mothers of newborns experience significant mental health problems range from 1:3 to 1:5, the most common of which are depression and anxiety states (e.g. 12.5 - 42% of pregnant women and, 12 - 50% of women of newborns in low and middle income countries (LMICs) screen positive for symptoms of depression). Suicide is one of the leading causes of pregnancy-related deaths (WHO report MMH2008).

Worldwide maternal mental health problems are considered as a major public health challenge. Though maternal mortality still lies at the heart of maternal health indicators; for the post 2015 agenda for development goals, WHO is considering proposing Healthy Life Expectancy (HLE) and

Universal Health Coverage (UHC) related indicators as well. This imply stronger focus on mental health conditions in the integrated delivery of services for maternal and child health. The need is not just felt in high income countries. In fact, some educational and public health institutions in low and middle income countries have already initiated integrated maternal mental health programmes. These have been low cost interventions with the involvement of non generalized or community health providers. Impact has been verified not only on mothers but also on growth and development of children.

#### Who is at risk of these disorders?

Almost all women can develop mental disorders during pregnancy and in the first year after birth of baby. Generally increase risks for specific disorders like low poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender based), emergency and conflict situations, natural disasters and low social support.

#### Effects of maternal mental disorders after birth on the mother and the infant

After the delivery, the mother with depression suffers a lot and may fail to adequately eat, bathe or care for herself in other ways. This may increase the risks of ill health. The risk of suicide is also a consideration, and in psychotic illnesses, the risk of infanticide, though rare, must be taken into consideration. Very young infants can be affected by and are highly sensitive to the environment and the quality of care, and are likely to be affected by mothers with mental disorders as well. Severe or prolonged mental illness hampers the mother infant attachment, breastfeeding and infant care.

#### What to do?

Maternal mental health can be integrated into general health care including women's health, maternal and child health care, reproductive health care and other relevant services.

#### What is the evidence base?

The National Institute for Health and Care Excellence (NICE) clinical guidelines make recommendations for the recognition, assessment, care and treatment of mental health disorders in women during pregnancy and the postnatal period (up to one year after delivery). It includes advice on the care of women with an existing mental health disorder who are planning a pregnancy and on the organization of mental health services.

It recommends that a Clinical Network should be established for perinatal mental health services managed by a coordinating board of healthcare professionals, commissioners, managers, service users and careers.

The NICE quality statement on postnatal care recommends that women who have transient psychological symptoms (baby blues) not resolved at 10-14 days after the birth should be assessed for mental health problems

#### Models in Maternal and Child Health Nursing: Normalization Process Theory (NPT):

NPT was the theoretical framework for the design,

implementation and evaluation of the MOVE model (Improving Maternal and Child Health Care for Vulnerable Mothers project), as it aims to support sustainability in health care behaviors, work practices and systems. NPT is based on sociological theory that extends individual explanation of behavior to predicts facilitators and barriers to normalization of new clinical practice. The theory conceptualizes types of work required for implementation, embedding and integration of complex interventions.

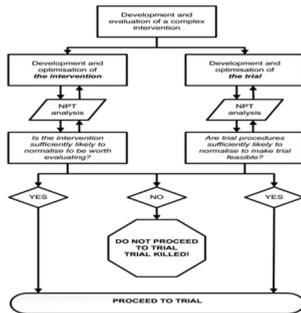


Figure 1

Normalisation Process Theory (NPT) as a 'trial killer'. Context: All important for development, evaluation and implementation.

#### The role of liaison psychiatry nurses in maternal Health:

Liaison psychiatry services may have a role to play in remedying these deficiencies in some areas, by setting up dedicated specialist teams and supporting the development of integrated perinatal mental health services based on a stepped care model of provision. The roles of the team would include: assessment; provision of psychological and other interventions particularly for complex cases; coordination and supervision of other services including IAPT for the treatment of mild/moderate problems; and consultation, supervision and training for non-mental health professionals, especially midwives and health visitors.

Particular emphasis should be placed on the early identification of problems, by promoting the screening of clients at their first point of contact with routine services.

A specialist service on these lines is provided in one of our sites, Hull. It takes referrals both from the obstetric department in the hospital and from midwifery and other services in the community. Referrals from midwives follow screening using questions recommended in NICE guidance ("During the last month, have you often been bothered by feeling down, depressed or hopeless?" and "During the last month, have you often been bothered by having little interest or pleasure in doing things?"). All potential cases identified by the screening are then assessed by the specialist mental health team, with follow-up treatment including psychological interventions as appropriate. The service in Hull was developed in response to a local need and represents one possible model for the improvement of perinatal mental health care.

Another survey of perinatal mental health support, carried out in the East Midlands, sought the views of relevant professionals including midwives, health visitors, GPs and obstetricians (Rothera & Oates, 2008). This identified a number of shortcomings, including:

lack of knowledge and skills among non-specialist healthcare practitioners to detect and manage perinatal mental health problems; difficulties in accessing psychiatric services; inadequate availability of systematic care pathways, protocols and guidelines; poor liaison between maternity, psychiatric and primary care services; and unclear roles and responsibilities.

#### What is paediatric consultation-liaison?

The Paediatric Liaison team remit is to offer assessment and treatment of psychiatric disorders related to physical illness, neuropsychiatric disorders, complex pain disorders and self-harm.

Pediatric consultation-liaison (CL) comprises all consultations, liaison, diagnostic, therapeutic, support and research activities carried out by psychiatrists and other mental health professionals in pediatric wards. The biopsychosocial approach holds a higher importance among paediatric age group due to multiple reasons: (a) they are at various level of physical, cognitive and emotional development; (b) family plays a very important role both in their health and illness; and (c) their understanding about illnesses, coping mechanism and the extent of disability vary from adult population. Pediatric CL as the process in which the child psychiatrist evaluates the patient, forms an opinion, and makes recommendations to the referring pediatricians (Burket).

There is at least four components play a major role in the illness and care of pediatric population: (a) the child, (b) the illness, (c) the family, and (d) the environment.

#### Need for pediatric liaison

The risk of psychiatric disorder in children with physical illnesses is approximately double compared to the healthy children. The psychological problems may be seen in 20-35% of the attendees at the pediatric clinics. These may range from psychological issues like difficulty in adjustment to a life situation to a diagnosable psychiatric disorder. The rates of somatisation among those with psychological problems may vary between 75-90%. In a survey of paediatric clinics of 14 countries by WHO9, the worldwide prevalence of medically unexplained symptoms was found to be 19.7%. Stress and anxiety is the most common underlying problem in medically unexplained symptoms, however parents often fail to identify them and seek multiple consultations. In a study by Perera et al in a paediatric setting, 51% of all the patients with medically unexplained symptoms had identifiable stressor and anxiety, but only 4% parents were able to identify the stressor. In another prevalence survey<sup>12</sup> of the representative sample attending paediatric out-patient, 20% of the children were found to have emotional and behavioural problems and out of them, only a quarter received child mental health services.

#### INDIAN STUDIES

In India, there is lack of studies on paediatric C-L services and its utilization. Various studies have reported paediatric referral rates to range from 7.5-8.6%. Further Awasthi et al reported that among all the paediatric referrals, 30% had no psychiatric illness, whereas in another 30% some psychological problem was present but no specific psychiatric diagnosis was made. Among those with psychiatric diagnosis, 'hysteria'(17.5%) was the most common diagnosis.

#### Role of pediatric in liaison psychiatry Nursing:

##### Consideration for the developmental perspective:

Paediatric age-group is a special group from developmental perspective – both physically and emotionally. They cannot be considered as mini-adults. Their response to stress and coping mechanism are based on their perception of illness and the level of their cognitive and emotional development which are different from adults. Thus, assessment and management needs consideration of the developmental stage of the child. Similarly, care has to be taken on how to explain about a medical procedure to a child depending on his/her developmental stage e.g. role play is more suitable, instead of a detailed explanation, for intravenous therapy in case of very young children.

##### Involvement of parents:

Parents are the main caregivers, chief interlocutors and

decision makers on behalf of minor children and, therefore, they play a significant role in influencing the attitude of child towards illness and treatment. Sometimes, they may also be the cause of the illness manifestations in the child e.g. psychosomatic symptoms in a child with frequent family conflicts.

#### **Assess the impact on child's siblings:**

The illness of a child not only affects the child but also his siblings. Often parents devote more time and resources on the care of the ill child, especially in chronic medical and psychosomatic illnesses. This results in frequent and long separations from other children, disturbance of daily routine; which in turn affects all the other components of the "network" by increasing distress in the child, parents and even increasing sibling rivalry.

#### **Role of hospital environment –**

The hospital is often a new environment for the sick child which deprives the child of familiar environment, siblings, friends and at the same time, exposes him/her to several new and potentially frightful experiences e.g. injections. The nature of reaction of a child often depends on the age, the length of separation from home and prior experience with hospitalization, the child's temperament, reaction of the parents, and mainly on the information and preparation given to the child. Separation from parents, especially mother, often results in depression, withdrawn behaviour and increasing vulnerability to physical illness which Rene Spitz described as 'anaclitic depression' or 'hospitalism'. At times, the hospitalization may offer positive experience by creating new and different relationships. The nature of reaction can be largely influenced by adequate information and preparation of the patient during admission.

#### **Composition of pediatric C-L team:**

The essential components of the team should include a psychiatrist with training or sufficient experience in child psychiatric issues, child psychologist, child and family psychotherapist and preferably a social worker and a child mental health nurse. The actual composition can vary depending upon the resource available and the number of referrals.

#### **Relationship with the paediatric team:**

As the child health service is a small community, the team should keep a close partnership and work in tandem with the paediatric team. Thus, the aim should be to not only provide clinical service, but also form a partnership between groups of colleagues. This will eventually influence the practice of paediatrics as well as of child and adolescent mental health. It also helps in removing stigma and prejudice against psychiatry, as the paediatric team gets sensitized to psychosocial issues and its management. Understanding the perceived need of the paediatric team and providing effective, readily available service is important.

#### **Child protection for abuse/neglect:**

Separate meetings with broader involvement of service providers like social workers and local authorities need to be involvement in ensuring the best possible psychological and physical care of actual or suspected child abuse. This is more important when the perpetrator of the abuse is a family member of the child.

#### **MODELS OF PAEDIATRIC CONSULTATION**

1. Emergency response model – To met the urgent demands like in emergency room and ICUs
2. Anticipatory model – for pre-assessment and pre-treatment like prior to a major procedure, breaking of a bad news, etc. This is mostly applicable in paediatric surgery units, cancer therapy etc.

3. Case finding model – consists of an early identification and treatment of the children and families which would benefit from psychological intervention. Mostly applicable in general ward and out-patient settings.
4. Education and training model – where the role of consultation psychiatrist is confined to giving opinion at joint clinical conferences, joint rounds and discussions.
5. Continuity and collaborative care model – when there is continuous and concurrent paediatric and psychiatric treatment. True liaisoning occurs in this type of model. This is often found in chronic and long-standing illnesses like diabetes, cystic fibrosis, genetic disorders and paediatric oncology. All the above models, like in general C-L psychiatry models, mostly differ with regards to the level of independence of the liaisoning psychiatric team and responsibility of the patients.

#### **Barriers to liaison between paediatrician and child psychiatrist:**

There can be several barriers to effective functioning of the pediatric C-L services. They delays in responding to a consultation or mismatch of the timings may deter a future referral. The approach to patient - directive approach of paediatrician versus persuasive approach of child psychiatrist - may at times create a conflict amongst professionals. This difference in approach is in form of body versus mind, lifethreatening aspects versus quality of life, cure versus care, and so forth. There should be mutual understanding and respect about these issues, instead of having inappropriate expectations, hierarchy and status issues. Close communication in the form of routine meetings and clinical conferences and understanding the way of work is the key to remove this barrier. Attitude of the patient and families may pose an important barrier in paediatric liaison as family plays a much more prominent role in decision making in case of a child. The dichotomous view of mind and body, the fact that they brought their child for 'physical' problems, and the stigma attached to psychiatric illness often brings resistance and reluctance to the treatment offered. This may be resolved to a certain extent by prior 'conditioning' of the parents by the paediatrician, involving the liaison team early in treatment course instead of seeking a delayed consultation when the medical examinations fail to reveal any result. The liaison team should also hold combined sessions with the patient and caregivers to explain the nature and cause of illness.

#### **CONCLUSION**

The risk of psychiatric disorder in children with physical illnesses is approximately double compared to the healthy children. Several psychological, familial and social issues may need attention, especially in case of chronic illnesses. Children are often at varying stages of cognitive and emotional development, which needs to be considered during assessment and management. Family factors attain a greater significance from an etiological and management perspective in case of children. Consultation and Liaison services geared towards pediatric population are likely to facilitate the early identification and management of mental morbidity in the younger population.

#### **REFERENCES**

1. National Institute for Health and Clinical Excellence (NICE). Antenatal and postnatal mental health: clinical management and service guidance CG192 London: NICE, 2014. Available from: <https://www.nice.org.uk/guidance/cg192>.
2. Chatterje B, Pattanaya RD, Sagar R. Consultation — liaison in paediatric population. Journal of Mental Health and Human Behaviour. 2012;17(3):S65-71.
3. NICE (2007) Antenatal and postnatal mental health: clinical management and service guidance. London: National Institute for Health and Clinical Excellence.
4. Rothera, I. & Oates, M. (2008) Managing perinatal mental health disorders effectively: identifying the necessary components of service provision. Psychiatric Bulletin, 32, 131-133.
5. Sharrock, J. & Happell, B. (2002) The psychiatric consultation nurse: thriving in

- a general hospital setting. *International Journal of Mental Health Nursing*, 11, 24-33.
6. Harpham T, Huttly S, Silva MJD, Abramsky T. Maternal mental health and child nutritional status in four developing countries. *J Epidemiol Community Health* 2005;59:1060-1064.
  7. Maternal mental health and child health and development in low and middle income countries : report of the meeting held in Geneva, Switzerland. 2008.
  8. Starting the conversation - Integrating mental health into maternal health care in India. *Indian J Med Res* 145. 2017 March: 267-269.
  9. Mccauley K, Elsom S, Muir- Cochran E. Midwives and assessment of perinatal mental health. *Journal of Psychiatric and Mental Health Nursing*, 2011:1-10.
  10. Henderson T. Pediatric consultation-liaison psychiatry: a description of the consultation-liaison service offered by a tertiary level children's hospital in Cape Town, South Africa. 2013.
  11. WHO maternal mental health. [https://www.who.int/mental\\_health/maternal-child/maternal\\_mental\\_health/en/](https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/)
  12. Taft et al. Maternal and child health nurse screening and care for mothers experiencing domestic violence (MOVE): a cluster randomised trial. *BMC Med*. 2015; 13: 150.