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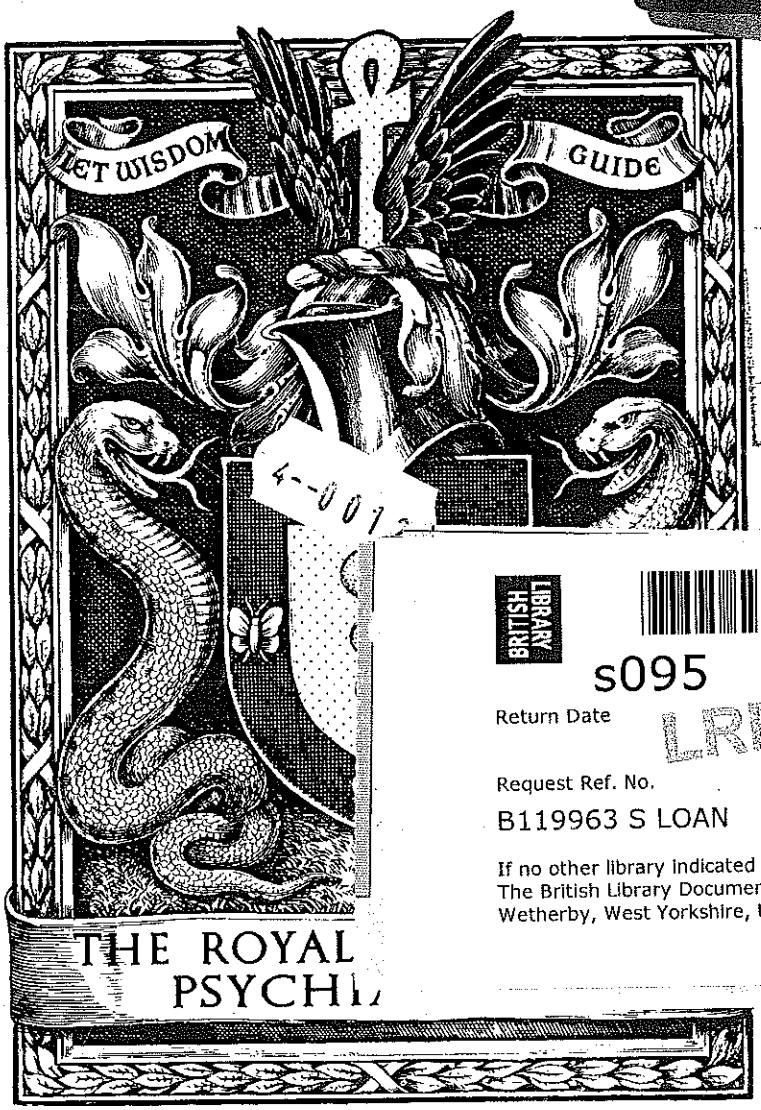

hild and Adolescent Psychiatry: Into the 1990s

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CHAPTER 16

CHILD AND ADOLESCENT PSYCHIATRY: INTO THE 1990's

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PREDICTING THE FUTURE FROM THE PAST

Remembering the Thirties
It dawns upon the veterans after all
That what for them were agonies, to us
Are high-brow thrillers, though historical
And all their feats quite strictly fabulous.
Donald Davie

This book is timely. It addresses itself to an overview of the issues in establishing comprehensive child mental health services. Although it dwells on the past, it also attends to current problems and looks for new ways of solving these. This is as it should be.

If observers of the scene in the 1960s and early 1970s were to be transferred to the 1990s, they might not find many similarities in the organisation and administration of services: change will be the byword. One may well ask whether it is possible to predict change based on circumstances prevailing earlier. It would be evident to the observers that while the past was clinician directed, clinic based and heavily therapy oriented, recent years reveal a changing panorama of policy, of planning and administration; of differences in philosophy, of prevention and intervention, and in the ideology of therapeutic approaches, management and care. Clinic based approaches have given way in the face of political pressures and the influence of local or regional strategies of care. Thus, whereas services in the past have often been driven by theory or ideology, in the 90s this will not be sufficient. Indeed, the 90s will provide a grand opportunity for allowing our theories and even our ideologies to generate hypotheses which can be tested in the vast and varied arena of clinical practice and clinical research.

Thus, clinical services in the 90s will need to be guided by, but not chained to, history and should be sensitive to those new concepts and developments that are considered to have currency in the post Great War era. It will be essential for managers of clinical services to undertake a critical re-examination of new issues and to attempt to solve the most pressing poblems; for example, the allegation that child and adolescent psychiatry is an expensive waste of time (see the chapter by William Parry-Jones); and this gives rise to questions not only as to whether our clinical intervention models are of proven efficacy but also asks questions about the quantity, quality and efficiency of the service provided. In relation to the former, the 1980s have done much to refute assertions of lack of efficacy (see Kolvin et al 1988a); and the latter are themes of audit and economic appraisal which are tackled in section III.

The observers might also enquire whether the changes were brought about by historical patterns alone. The answer must be no: some are likely to have arisen from new developments in clinical practice. For example, it would not have been possible to predict the drama of the crises of child sexual abuse in Cleveland, particularly those appertaining to the issues of assessment and management of children and families (Kolvin et al, 1988b), nor the public scrutiny of aspects of such clinical practices in paediatrics and, to a lesser extent, in child psychiatry (Butler-Sloss 1988). Furthermore, it would not have been foreseen that the assessment techniques of both paediatricians and child psychiatrists would be subject to the penetrating logic of the law (Jones and McQuiston 1988), nor that the major expansion of forensic child and adolescent psychiatry would call for new knowledge and exceptional skills (Black et al 1989).

Many changes are politically inspired; for instance, the White Paper's (1989) claim to improve the care of patients, both in and out of hospital. Politicians often offer mixed messages: for example, there has recently been widespread destruction of the community-based child guidance clinics, yet in the same breath politicians argue for the relocation of mental health services within the

community! These politically led strategies may be expressed in regional strategic plans but, as Ann Gath points out in chapter fourteen, these methods will have less force in the future, as the Regional Health Authorities have been emasculated to a certain extent by the NHS Act (1990). There are now other actors in this drama, namely, the local managers of local trusts - the new brain child of politicians.

Do we resist change or do we seek some form of compromise?

Resistance is likely to be counter-productive; hence, there are good reasons for going along with Ann Gath's view that there needs to be sharing of ideas and expertise, bearing in mind that those who are in the most strategic position for finding correct answers to fundamental questions are those currently providing services in the districts themselves. Further, managers and clinicians need to be responsive to developments in Western Europe and in North America. The exercise of audit is already well established in North America, whereas it is only at a preliminary stage in the United Kingdom and yet child and adolescent psychiatry appears strategically poised to deal with these complex issues (see chapter nine).

Perhaps the most crucial task of the 90s is to define our role. Aspects of this are covered in the contributions by Taylor and by Cox and Wolkind (see chapter four). They emphasise the unique training of child psychiatrists and highlight their clinical strengths, compounded of knowledge, skills and experience. Whilst defining this unique contribution, they do not deny that there may be some degree of overlap with clinicians in other disciplines. They also highlight the need for child psychiatrists to be aware of the contribution of other professionals, and to share with them the tasks of assessment, treatment and management. This is not sufficient: the 90s will be an era of scrutiny, of theories, assessment techniques and wider clinical practices. There will be scrutiny by peers in our own and allied disciplines, by managers, by local agencies, and direct and indirect scrutiny of clinical research. In this, child psychiatry will be no different from many other disciplines in the clinical field. We will all be expected to demonstrate the quality of our care of patients, both in hospitals and in the community. In the circumstances it will be preferable for us to establish our own systems to examine our practices and to set our own standards, rather than to have them imposed.

Thus, inevitably, there will be continuing change, and it is sensible for us to plan for change. Some changes will be for us alone to devise; others we may have to model on those of other professional disciplines. For instance, in paediatrics there are two broad directions: these are community and behavioural approaches on the one hand and high technology approaches on the other. It may well be that, in planning our services, we need to take both into account. Planning for practice in these areas will have to take into consideration training, skills, needs and demands.

Finally, there is the matter of manpower discussed by Peter Hill (chapter twelve). Many consultants in the U.K. are single-handed or work in small teams while dealing with relatively large catchment areas and the question arises as to how they manage to cope with their heavy burden of work. In an unpublished survey carried out by myself on behalf of the Child and Adolescent Section and also Council, I ascertained that some tried to give as good a service as possible using a "face-to-face" approach for about 90 per cent of their patients; others combined the "face-to-face" work with consultation (see chapter eleven) and by these means tended to see large numbers of patients; some suggested that they maintained a low profile to avoid being overwhelmed by work. For all of them a common factor was very long hours. However, there were dangers inherent in this situation in that certain emergencies would be dealt with after hours in the absence of other staff; the consultant then, especially if female, could well be faced by some potentially dangerous parents or patients. All felt cutting corners was inevitable, but carried the danger of missing something crucial; some consultants had imposed an upper age limit on their patients. Fortunately, in almost all, the long day was followed by little in the way of evening or weekend work, otherwise these heavily pressed clinicians would have been "on call" for 24 hours a day. Many of these consultants, especially those without other medical support, relied quite heavily on colleagues in allied disciplines to share their work. Many expressed concern about the threatened reduction in the numbers of social workers which would seriously reduce not only the number of cases they were able to deal with but also the thoroughness with which they

were assessed. There were also questions about allocation of priorities. Almost all agreed that high priority should be given to the acute cases but often differed with regard to time-consuming complex cases, to court cases and to routine work. Although most of those colleagues made a considerable effort to contribute to administration, attend committees, etc., a number queried whether these endeavours justified the time spent on them in the light of the shortage of time for clinical practice.

Then there are the wide community and specialist agency expectations of child and adolescent psychiatrists irrespective of the size of their supporting teams. In the circumstances, it is all too easy for other professionals to minimise the contribution of child and adolescent psychiatry, partly because of the numbers involved and partly because of the rapid expansion of the other disciplines. In a general population of 100,000, there will be about 20,000 children of school age or younger, probably cared for by four or five paediatricians and community paediatricians, half a dozen clinical and educational psychologists, scores of social workers and probation officers, hundreds of teachers and probably the equivalent of merely one child psychiatrist. These ratios may be less disproportionate in teaching districts. A fuller account of manpower issues is given in the chapter by Peter Hill (see chapter twelve). One solution for dealing with such high expectations when confronted with small resources, is that the child and adolescent psychiatrist when planning services, should seek ways of organising themselves into functional teams (see Judith Trowell, chapter fifteen). In this way they can maximise their contribution to the local community and to the health service. Second, for community and hospital services to work properly, a number of conditions must be met. For instance, it is not possible to function properly where a single-handed consultant is poorly supported. Thus both the quantity and quality of the service is going to be heavily dependent on appropiate supports from non-medical colleagues; consultants should try to share the clinical load with other disciplines. Third, consultants should plan to develop a judicious combination of "face-to-face" work and consultation. Fourth, close links must be fostered with the local community and other services; a particular consideration is the provision of regular, but not necessarily frequent consultations to a variety of agencies (such as special schools, social services etc.). Fifth, on the administrative side, child psychiatrists require efficient clerical and secretarial back-up. Next, regional day and in-patient units need to respond favourably and preferentially to requests for assessment and admission of patients of consultants working in small teams or on their own. Finally, time should be allocated for reflection and continuing post-graduate education (see chapter six).

I consider it an honour to be invited to write the final contribution to this collection of papers, which are centred on the substantial changes that have occurred, and that continue to occur, in practice and service. Over the last decade there has been a dramatic change in the emphasis of clinical practice, and we should query what was responsible for this. Chess (1988) has already provided a reasonably comprehensive overview of the issue: not only has there been an explosion of research (see Berg, Chapter 8) with a concommitant expansion of knowledge and new ideas, but also there has been increased willingness to pose critical questions and to attempt to answer them. In many ways, British child psychiatry has made a signal contribution to such exercises. These academic and scientific developments have begun to influence concepts and practice. Clinicians are no longer daunted by research nor by statistics as hitherto. In reciprocation, the researcher has begun to value the experience and theories of clinicians as an invaluable source of research ideas. Co-operation, rather than antagonsim, has become more common. These are some of the issues that have led Stella Chess (1988), from her survey of major developments in child and adolescent psychiatry over the past fifty years, to conclude that the specialty has grown dramatically and has now come of age.

Thus I confidently believe that this collection of papers will be perceived as a landmark of expectations in the practice and planning of services of child and adolescent psychiatry. Indubitably, prospect of change, compounded by the ever-increasing complexities of practice and service, will often generate a pessimistic outlook which may prove rather daunting to the novice and expert alike. Nevertheless, there is also an attractive challenge. Clinical practice and the corresponding services have now the prospect of a sound basis. The diversity of themes in this collection reflects the range of practical knowledge of skills that are practised, and there is evidence that such knowledge and skills have been carefully collated so that the novice in our

discipline and professionals in other disciplines can achieve an understanding of our aims and objectives. In the past the paradigm of child and adolescent psychiatry was the issue of therapy; we have not discarded this but, rather, we encompass now a much wider concept of practice. The roles, responsibilities and work of the specialist in child and adolescent psychiatry are better defined (see Chapter 5 by Dora Black). The organisation, planning and developing services have now a sounder basis (see chapters 11 and 12), and due attention is given both to measuring the service (see chapter 9) and the utilisation of modern information technology in monitoring practice and service activities (see Chapter 10 by Ed Sein). Thus this collection of papers and the scholarship contained therein provide a substantial guide to current practice and an important springboard into the 1990s.

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