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Ms Valerie Hynes, team administrator; Dr Gerardine O'Keeffe and Dr Tracey Heads, consultant forensic psychiatrists; Ms Karen Chambers, clinical nurse specialist, and the patients and staff on Rollo May Ward.

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Niamh Power Specialist Registrar in Forensic Psychiatry, John Howard Centre Medium Secure Unit, London, **Dawn Harwood** Ward Manager, ***Akintunde Akinkunmi** Consultant Forensic Psychiatrist, Rollo May Ward, Tony Hillis Wing, St Bernard's Hospital, Uxbridge Road, Southall UB1 3EU, e-mail: Akintunde.Akinkunmi@wlmht.nhs.uk

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HILARY LLOYD, MARGARET BAMFORTH AND MARY EMINSON

Using the scarce resource of child and adolescent psychiatrists equitably

The authors, all consultant child and adolescent psychiatrists working in the north-west of England (an area that has experienced recruitment difficulties throughout the past decade), seek to stimulate discussion about the serious issues of recruitment and retention faced by child and adolescent psychiatry. Current thinking about staffing and models of provision is challenged.

Child and adolescent psychiatrists are a scarce resource. Some services have used the recent investment in child and adolescent mental health services (CAMHS) to create new consultant posts. However, the workforce to fill these posts has not been created. Furthermore, the National Service Framework for Children (Department of Health, 2003) states that CAMHS must expand by 10% year on year for the next 3 years. Whether the 10% is defined as resource, budget or personnel, it is to be expected that there will be some increase in number of child and adolescent psychiatrist posts therein.

The crisis in recruitment

Certainly, the National Service Framework expectation that all CAMHS will extend their age range to 18 years by 2005 will bring an increase in demand for child and adolescent psychiatrists. The College has recently redefined the norms for consultant child and adolescent psychiatrist staffing levels, reducing the total population served per consultant from 100 000 to 67 000 (Royal College of Psychiatrists, 2002). Yet there are services that have no consultant in post, and that have been unable to recruit for several years. There are unfilled National Training Numbers in our specialty and, consequently, little expansion in trainee numbers.

There are particular reasons why child and adolescent psychiatry trainees are filling less of the recruitment gaps than was expected. An increasing number of trainees wish to train and then to work flexibly, and individuals from double-income families may have domestic reasons for being able to consider consultant posts in only a limited geographical area.

It seems to remain the case that well-resourced services are going to find it easiest to gain College approval for new consultant posts. These tend to be in centres of education and population. Services in more remote areas are, with exceptions, disadvantaged.

What are the recruitment 'black holes' to do? Services that have been unable to retain and/or recruit may be able to create more posts (finding a stash of new money, or reviewing priorities within the current budget) that gain easy approval from the College. However, if there is an overall shortage of specialist registrars graduating from training schemes, creating new consultant posts will not solve the overall problem, although the vacancy may shift to another locality. There are services that have created new posts from modernisation monies, yet have struggled to recruit. Services that have had no psychiatrist for a long period, have only one post for a large population or are distant from major cities will continue to face problems.

Thoughts about using the glut of young paediatricians by fast-tracking training conversions are coming to fruition, but it is still a long wait to the harvest. Courses in psychopharmacology for paediatricians, teaching something about medication for attention-deficit hyperactivity disorder (ADHD) and Tourette syndrome, are all very well if paediatricians have adequate training in the assessment and other aspects of management of these disorders. This is questionable on current evidence.

Moreover, the problem remains of ensuring that one's postcode does not dictate whether one can get access to the advice of a child and adolescent psychiatrist. Child and adolescent mental health teams without

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psychiatrists may flounder and lose staff, or they may continue but struggle with those cases that need the specialist input. Other teams act as though they do not need a psychiatrist in any event, and acknowledged need dissipates while crises multiply and quality of care diminishes.

A new service model

If the simple fact is that, for the foreseeable future, there will not be sufficient consultant child and adolescent psychiatrists to ensure that CAMHS have a consultant, let alone one consultant per 67 000 population, then radical thinking about meeting service needs is called for. In order to prevent further development of a 'postcode lottery', we suggest some service redesign and change in the *modus operandi* of child psychiatrists and CAMHS teams. This would involve careful prioritisation and use of the scarce and expensive resource of consultant child and adolescent psychiatrists.

First, the clinical issues for which the skills and advice of child and adolescent psychiatrists are essential must be clearly defined. We suggest that they are as follows:

- identification and treatment of psychosis;
- identification and treatment of severe depressive illness;
- identification and treatment of organic mental states;
- identification and treatment of severe somatoform disorders;
- advice in respect of high risk of self-harm, suicide and harm to others;
- identification of mental health issues in complex cases;
- formulation of, and advice in, complex cases;
- advice on treatment of severe, complex, refractory ADHD, obsessive–compulsive disorder and Tourette syndrome;
- advice on and management of anorexia nervosa;
- certain types of paediatric liaison work;
- psychopharmacology;
- assessment of complex or atypical autism-spectrum disorders.

Second, the skills and competencies of the rest of the multidisciplinary CAMHS team must be defined. These may vary from team to team according to composition and experience, but we suggest that most teams, irrespective of whether they have a consultant, should aim for the following:

- initial formulation and differential diagnosis of most cases;
- risk assessment of self-harm and harm to others;
- formulation and management of most cases of self-harm and harm to others;
- initial ADHD assessment, and treatment of milder cases not needing medication;
- family therapy clinics;
- parent management skills;
- cognitive–behavioural therapy;
- behaviour modification;
- casework.

A staff-grade psychiatrist, clinical assistant or interested paediatrician could be trained to:

- assess and interpret relevant medical issues;
- identify and prescribe for Tourette syndrome;
- prescribe for obsessive–compulsive disorder;
- prescribe for ADHD;
- make neurodevelopmental assessments, organise and assimilate occupational therapy, speech and language therapy and physiotherapy assessments into treatment plans.

Third, consultant child and adolescent psychiatrists need to be open to new ways of working, acknowledging their own highly specialised skills and competencies and being prepared to offer them beyond their core CAMHS team or base. Consultants would:

- develop outreach consultation clinics with other CAMHS teams;
- negotiate sessional commitment according to local need and availability;
- offer some direct review;
- consider the use of telemedicine to support services.

This would require consultants to embrace significant changes in their patterns of working, and issues of clinical responsibility would need to be carefully thought through. Trusts would need to invest in equipment to allow regular teleconferencing. It is not likely to be appropriate for consultants to carry clinical responsibility for cases when working in this way, although they would remain responsible for their professional opinion and advice offered.

Child and adolescent mental health teams would need to develop robust initial assessment and intervention protocols and guidelines, and effective ways of triaging cases for consultant attention. A manual, along the lines of that developed by Vikram Patel (Patel, 2003), for mainly adult services in developing countries, would be highly useful. Means of accessing tier 4 services, including in-patient beds, would need to be carefully worked out, in collaboration with those services. Advice upon strategic issues might also be sought from the 'visiting' consultant.

Finally, support for such developments would need to come from the management of trusts employing the consultant child and adolescent psychiatrists who provided this service to another CAMHS team. The consultants would need to be freed from some duties in their home service, and the new way of working should be acknowledged in job plans and in the appraisal process. The consequences for the home teams should be acknowledged and catered for. The advantages of such a system would be:

- greater equity of service;
- availability of services for the most needy;
- closer working relationships between different CAMHS;

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- consultants remaining closely linked with their home core team;
- scope for the development of regional specialisms.

The model is suggested at a time when there is interest in developing clinical networks and is seen as being entirely consistent with this. Indeed, to some extent, the model could become the ultimate clinical network. However, it is not seen as a permanent answer to the consultant shortage: it is simply a suggestion to meet the need in the absence of evidence of other means of doing this in the short to medium term. The model would need to be embraced by the College, so that new posts that follow it could be approved.

Declaration of interest

None.

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Hilary Lloyd Consultant Child and Adolescent Psychiatrist, Royal Manchester Children's Hospital, Manchester M27 4HA, e-mail: hilary.lloyd@cmmc.nhs.uk, **Margaret Bamforth** Consultant Child and Adolescent Psychiatrist, Thorn Road Clinic, Runcorn, **Mary Eminson** Consultant Child and Adolescent Psychiatrist, Royal Bolton Hospital, Bolton

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