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Consultant norms in child psychiatry

(1990 Update)

The College last recommended norms for consultant child psychiatry posts in 1983. At that time there were 278 whole-time equivalent consultants in post. It was felt that in terms of realistically meeting need this figure was grossly inadequate. The recommendation for the irreducible minimum was 2 consultant posts per 200,000 of population, whereas the realistically desirable was 3 per 200,000. These figures would have required 490 and 735 WTE consultants respectively.

Position since 1983

There has been a steady but slow expansion of consultant numbers to a figure of 335 in 1987, a rise of approximately 20%. Many districts have reached the lower figure recommended in 1983, virtually none the higher. There remains very great variation both between and within regions. Alarmingly a single consultant for a population of 400,000 remains not uncommon.

The JPAC proposals

At present there are 120 senior registrars in child and adolescent psychiatry. JPAC has recommended a national target of 148. Assuming this target is met, 37 SRs will be eligible for consultant appointments each year. Over the next 10 years, it is estimated that 18 consultants will leave the NHS each year. This implies a rise of 19 new consultant posts each year and in 8–12 years the 1983 irreducable minimum level would be reached. The JPAC quota was increased to 156 distributed through the regions of England and Wales as from November 1990.

Current recommendations

The falling number of children in the community would suggest that the level of demand might fall. Other factors, however, are in operation which have caused demand to rise and suggests it will continue to rise even further.

(1) Child psychiatrists are increasingly being required to be involved in child abuse and protection work. It has become clear that they have an important role to play and also that this work is very time-consuming (Wressell *et al*, 1989). The implementation of the Children Act 1989 will further increase the volume of work.
(2) There has been a great demand for child psychiatrists to expand the age range they work with and many are seeing increasing numbers of 16–20 year olds. This is particularly the case with young people who continue to suffer the effects of conditions arising in childhood such as autism and other developmental disorders.
(3) College policy has rightly stressed that in many districts in the country it is the child and adolescent psychiatrist who should provide the services for children with mild and severe learning difficulties who also have psychiatric illness. This new demand is challenging and time-consuming.
(4) The original figures did not include any allowance for teaching. For teaching distrists the accepted formula is to multiply the norm by a factor of 1.6. It should also be noted that demand for teaching has increased greatly in all districts with the child psychiatrist being seen as having an important role in the training of both Health Service and local authority workers.

Other factors are at work which suggest that many districts will, even if they reach the higher 1983 figure, still not be providing a service which can meet even the most pressing demands.

(1) In certain districts, mostly in inner city areas, the child population is rising very rapidly. These same districts are marked by social conditions which all relate to very high rates of child psychiatric disorder.
(2) Traditionally the child and adolescent psychiatrist has been a member of the mental health team. Therapeutic work for children could be offered not only by the psychiatrist and other NHS professionals but also by local authority educational psychologists and social workers. These latter groups now spend an increasing amount of their time respectively on statutory duties concerned with the Education Act and child protection work. The child and adolescent psychiatrist must now provide an increased amount of treatment if the needs of referred patients are in any way to be met.

There is now convincing evidence that untreated childhood psychiatric disorder has major human and financial implications for the individual and the community and equally that

there are effective treatments which can improve the prognosis for a child. The signs are that in approximately ten years we will have reached a point where a minimal service should be available nationally. Looking at medical manpower projections, it would be unrealistic to call for a set of new increased norms. The solution will have to lie in ensuring that every district at least meets the 1983 norms, but equally that other Health Service professionals such as community psychiatric nurses and child psychotherapists are available to participate in this work. Serious consideration should be given by health districts to providing other forms of workers, such as family and behavioural therapists, who can assist consultants in their work.

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Research by trainees

A report by the Working Party of the Collegiate Trainees' Committee

Introduction

The vexed question of research by psychiatric trainees has continued to plague us. In 1980 the Royal College of Psychiatrists devoted an entire session of the autumn quarterly meeting to psychiatric research, the papers later published in the *Bulletin* in 1981.

Professor Goldberg (1981) described a new course – Encouraging Psychiatric Trainees to Undertake Research. Hollyman & Abou Saleh (1985) reported the findings of a survey of Southern Division trainees performed by Waters in 1980. It was apparent that by 1985 several centres nationally had begun local courses in research methodology. However, in 1986 reports began reaching the Collegiate Trainees' Committee from Divisional Trainees' Days of concern being voiced by trainees themselves. Crauford *et al* (1986) highlighted this area in their report of the North West Trainees' Day.

Two main problem areas were noted. Trainees felt under pressure to 'do research' to enhance career prospects when they felt the time to learn or develop clinical skills was limited already, a view expressed particularly by post MRCPsych registrars, competing for SR posts, given the current bottleneck at this level. Further, having decided to embark on research, multiple practical problems in carrying out the research were being encountered and training, advice, and practical support were hard to obtain.

A working party was convened to examine some of the issues and try to discover the current situation.

Method

Information from the trainees' days was noted. A questionnaire was distributed to 890 trainees in five divisions of the College. The three main sections covered demographic details, research training, experience and supervision, and finally an open narrative section on how the situation might be improved.

Results

There was a 33% response rate with 296 usable questionnaires returned. The demographic details showed an equal response rate from all divisions sampled. The respondents posts held are skewed