

would be used to confer full specialist status and the FRCPsych qualification.

Nobody will be hurt any more by being overlooked for the Fellowship. The present By-law structure, without need for further reference to the Privy Council, will provide us with senior trainees on all important committees and we shall have a reasonably lengthy specialist training with which to start to negotiate reciprocity with some other countries.

I have carefully avoided going into the question of the

form of the examination with which to 'exit' into FRCPsych and glory. As a final, genuinely Canadian comment I should say that the FRCP(C) examination in psychiatry is under considerable criticism. Perhaps the time is ripe for a pleasant collaborative conference between representatives of our Colleges in a suitable location equipped with para-conference facilities. Either Nova Scotia or Newfoundland would be more or less equidistant between London and Central Canada; they are scenically gorgeous and the sailing and fishing rival Ireland or Scotland.

Child and Family Psychiatry: Planning for Survival

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If Child Psychiatric Services are to survive into the 1980s, we believe that practitioners will have no alternative but to make sense of the complicated administrative network on which their future depends. This is an account of one such attempt by three Child and Family Psychiatric teams working in a Health Authority Area.

In an earlier paper¹ we described how one local authority met the recommendations of a Joint Circular² which asked for the formation of interdisciplinary working parties to report on the future provision and organization of child guidance via Joint Consultative Committees to the Department of Health and Social Security and the Department of Education and Science by December 1976.

The Bedfordshire Joint Consultative Committee report of March 1977 stressed that the Child and Family Psychiatric Service (formerly the Child Guidance Service) should be represented on relevant planning teams, and noted the Joint Circular's recommendation that Joint Consultative Committees should keep under review agreed arrangements between authorities for the maintenance of child guidance services.

After the relevant reports had been accepted, the former Child Guidance Study Group was reconvened to discuss future policy; this was undertaken by specialists in community medicine (Child Health and Social Services). They called together representatives of the child guidance network, including the new separately administered Education Psychological Service, and the Child and Family Psychiatric Service (jointly staffed by the National Health Service and the Department of Social Services).

Two complementary study groups were created, with members in common, each with access to appropriate sub-committees of the Area-based Joint Care Planning Team and thence to the Joint Consultative Committee.

1. Interface Group

To be chaired in rotation by Social Services and Education Department administrators and Community

Physicians: its brief to clarify the complementary and at times overlapping roles of specialist resources within the network of services for children and their families. Because the Education Psychological Service had become a separate one, this was the only forum in which joint planning could take place between the Education Department, the Education Psychological Service and the Child and Family Psychiatric Service.

2. The Child and Family Psychiatric Service Joint Planning Group

Social Service administrators, Community Physicians and practitioners* agreed (i) to act as a planning group able to make recommendations to the Mental Illness Sub-committee of the Joint Care Planning Team; (ii) to monitor the Child and Family Psychiatric Service on behalf of the Area Health Authority and the Department of Social Services.

These arrangements were made so that the Interface Group could tackle the necessary but often acrimonious interagency battle about the use of current resources, while the planning group focused on a more limited yet urgent brief, the maintenance of community-based psychiatric services for children and adolescents during a time of increasing economic stringency.

The planning group agenda included (i) future adolescent psychiatric provision; (ii) emergency responsibilities and (iii) future input of resources. The Community Physicians asked that items (i) and (ii) be dealt with first, and the practitioners subsequently felt that they had made a tactical mistake in agreeing to this request. As a result, although working in a service with no beds, junior doctors or nursing staff, and with switchboards available only from 9 am to 5 pm, they became recipients of community anxieties about self-poisoning

*The practitioners were representatives of the three Child and Planning Psychiatric Service teams, and consisted of psychiatrists, social workers, a child psychotherapist and a play therapist.

adolescents admitted to hospital, and about adolescents in Children's Homes and adult psychiatric wards presenting with difficult behaviour. It was implicitly expected that they could provide an alternative to the regional Adolescent Unit which resisted, rightly in our opinion, the labelling of difficult to control teenagers as psychiatrically ill patients meriting unquestioned emergency admission.

After a year (December 1979) the practitioners forcibly moved the agenda to item (iii). The Deputy Director of Social Services and the Specialist in Community Medicine (Child Health) now said that there was no foreseeable opportunity for strengthening the service and no guarantee that vacated posts would not be frozen. This made it clear that not only is there a permanent gap between existing resources and community and professional needs, but also that *both* planning groups had focused only on the task of transmitting demands to the currently available service. The practitioners are seeking (outlined below) more constructive ways of measuring and communicating about the work load.

1. At present each clinic is asked to supply quarterly statistics about new and follow-up cases seen by the psychiatrist.

We are not asked to record consultative work with other professionals, work done by non-medical members of the team, or work done outside the clinic base. The figures at present supplied are virtually meaningless, and we have asked the DHSS to revise the way in which clinic statistics are collected. We have also asked for up-to-date guidelines about the management of self-poisoning adolescents under the age of sixteen.

2. The Executive Committee of the Child and Adolescent Psychiatry Section of the Royal College of Psychiatrists has also been asked for guidance about self-poisoning adolescents and for comments on current community demands for the undertaking of emergency responsibilities by small, out-patient multidisciplinary teams each containing only one medical practitioner. We have pointed out, in addition, that the provision of teaching by child psychiatric teams for trainees in general psychiatry requires monitoring at Regional level and by the College. The Section has since set up working parties to explore these issues.

We have published various articles about our work and have taught locally and more widely.

Objectives for 1980

1. NHS re-organization

When one tier of the NHS is removed, as is intended,³ services organized at Area rather than at District level, and tenuously linked with planning committees, may be at risk, and it is unclear what national arrangements for child psychiatric services will follow. Recognizing that the Child and Family Psychiatric Service faces legitimate competition from adult psychiatric and paediatric departments, whose needs are perhaps more readily identifiable, our planning

group has asked the Joint Care Planning Team for advice about local arrangements. The psychiatrists have achieved representation on District Operational Groups for primary health care, children's services and the mentally ill, and also on a newly formed group of child psychiatrists practising in the North West Thames Region. We expect to spend a lot of time in committee rooms.

2. Adolescent Psychiatry

With regard to future planning, our group will recommend the recording quarterly of the numbers of parasuicidal adolescents between the ages of 12 and 16 treated in casualty departments or admitted to hospital wards, together with offers of follow-up (and their take up rate) to the legal guardians of these adolescents. The Area Health Authority and Local Authority are co-terminous and a child psychiatrist⁴ has recommended, in a locally circulated paper, interdisciplinary evaluation at this level of resources for adolescents. Our planning group hopes to take part in this exercise which will also help evaluate a current proposal to finance an additional, Area-based consultant specializing in adolescent psychiatry.

3. Funding

Preliminary information suggests that our service gets about one-thirtieth of the NHS funds allocated to the hospital-based adult psychiatric service. We question this use of resources and propose to ask the Joint Care Planning Team for a more accurate breakdown and evaluation of current spending, pointing out the resource implications for the Child and Family Psychiatric Service if we are to teach psychiatrist trainees preparing for the MRC Psych. or DPM. We have also asked for joint funding of some social work posts.

Discussion

Small, specialist community-based services, organized at Area rather than at District level, and gambling as to which committees will represent their interests, may be yet more at risk in the course of further NHS reorganization. Their practitioners will continue to be torn between the wish to develop and evaluate an effective clinical service, and the essential but time-consuming attempt to take part in rational, long term planning.

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