precedence over other services, including work provisions, and thus the current plans have ignored the fact that there are still some day patients who work on the hospital site. The management has also yet to be convinced that rehabilitation is not a time-limited course, ending in discharge and effecting economies; community rehabilitation projects are, in fact, labour intensive and they need a perpetual input of expensive professional time.

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Consultant manpower in child psychiatry

North East Thames Region

This paper has been prepared by the North East Thames Child and Adolescent Psychiatric Advisory Sub-Committee (NETCAP) in order to draw the attention of the Region to deficiencies in consultant child psychiatric services in the Region. It sets out below the population of each district and the current consultant manpower. These figures have been obtained from the district general managers and in some cases corrected by the local consultants.

In 1973 the Royal College of Psychiatrists[1] recommended that the realistic minimum requirement for child psychiatrists was 1.5 per 200,000 population with a further 1:500,000 for adolescence. Even by these now outdated standards the NET Region is three consultants short (see Table I). In 1978 it was recommended that these figures be increased by a factor of 1.6 for teaching districts to take account of the extra manpower requirements for teaching medical students and research.[2] In 1983 the College revised its recommendations, taking into account the expanded role of child psychiatry because of effective treatments such as family therapy which "now enables psychiatrists to tackle problems of childhood and adolescence which were previously insoluble" and other factors. It recommended an "irreducible minimum" of two consultant child and adolescent psychiatrists per 200,000. We are five consultants short of that standard. However, the College 1983 "realistically desirable" standard was 3:200,000 population with an extra loading for teaching districts.[3] By these standards we are 29.5 consultants short. We have not included in the district figures the Tavistock Clinic, the Hospital for Sick Children and the regional adolescent units consultants in these calculations as they serve as tertiary referral clinics. They add another 17 consultants to the total for the region. If they are included we are still over 12 consultants short on 1983 recommendations. These recommendations were made five years ago. Since then there have been many developments which have increased the demand on child psychiatric services, outlined below.

Increase in marital breakdown

In the past 15 years, the divorce rate has more than doubled, and many of these divorced parents remarry. Children of divorce more likely to become disturbed than children from intact families, and more likely to be referred to child psychiatric services.

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TABLE I
Consultant child psychiatrists
NET Districts

District	*Total population*	*Present estab. of consultants*	*1973 minimum requirement (RCPsych)*	*1983 irreducible minimum (RCPsych)*	*1983 realistically desirable (RCPsych)*	*1988 shortfall in consultants*
Barking, Havering & Brentwood	458,100	2.9	4.5	4.6	6.9	4.0
Basildon	281,021	1.6	2.7	2.8	4.2	2.6
Bloomsbury (excluding GOS)	133,900 T	2.0	1.4	1.3	3.2	1.2
City & Hackney	191,921 T	2.8	1.8	1.9	4.8	2.0
Enfield	261,500	1.0	2.5	2.6	3.9	2.9
Hampstead (excl. Tavistock)	111,348 T	0.8	1.0	1.1	2.6	1.8
Haringey	197,856	1.7	1.9	2.0	3.0	1.3
Islington	167,900	1.9	1.6	1.7	2.6	0.7
Mid Essex	286,806	1.5	2.8	2.9	4.5	3.0
Newham	205,000	3.0	2.0	2.0	3.0	0.0
N E Essex	280,000	1.0	2.6	2.8	4.2	3.2
Redbridge	226,280	2.2	2.1	2.3	3.5	1.3
Southend	320,000	1.8	3.0	3.2	4.8	3.0
Tower Hamlets	152,800 T	2.4	1.3	1.5	3.7	1.3
Waltham Forest	215,834	2.4	2.0	2.2	3.3	0.9
W Essex	250,000	3.5	2.4	2.5	3.8	0.3
Total		32.5	35.6	37.4	62.0	29.5
Tavistock Clinic* T (Hampstead Health Authority)		7.7				
Hospital for Sick Children* T (Special Health Authority)		5.2				
Regional Adolescent Psychiatrists = 4					District shortfall 29.5 Overall shortfall 12.6	

Notes T = Teaching District. The proposals for these districts are calculated as 3/200,000 population × 1.6
* Both these clinics serve as tertiary referral clinics and therefore are not included in consultant establishments of the districts in which they are situated.

Child sexual abuse

There has been an explosion in the rate of referrals to all child psychiatrists and particularly to those in metropolitan districts for this condition. Diagnosing the condition and arranging treatment for the victims and other members of their family takes up an inordinate amount of child psychiatry time now, whereas in 1983 it was rarely seen.

Forensic work

In 1983, child psychiatrists were occasionally asked to be expert witnesses, usually in magistrates' courts, with children who were delinquent. In the last five years, there has been a vast increase in expert witness work involving child psychiatrists. Some of this is related to child sexual abuse, but there has also been an increase in other fields, particularly in child care work, freeing for adoption, contested access and custody cases, etc.

Teaching

Thanks to the efforts of child psychiatrists, there has been a steady increase in the amount of the undergraduate curriculum which is allocated to this subject. This has manpower implications. In addition,

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there has been an increase generally in post-graduate medical centres and there has been an increasing recognition of the need for doctors in many different disciplines to have a grounding in child psychiatry, including paediatricians, community health physicians, general practitioners, and adult psychiatrists. Non-medical professions, such as nurses, teachers, psychologists, social workers and psychotherapists also make demands on child psychiatrists for teaching and post-graduate supervision.

Treatment

There has been an increase in the range and effectiveness of therapies available in the child psychiatric departments. This has increased the clinical load on child psychiatrists and their colleagues.

Liaison services

The majority of child psychiatrists used to practise in child guidance clinics, which were often not attached to or in the vicinity of paediatric wards. All this has changed. In addition, there has been an increase in the practice of 'high tec' paediatrics. Children undergoing, for example, renal dialysis and transplant, or bone-marrow transplant, and their families, are under enormous stress both because of their disease and its treatment. The services of child psychiatrists are increasingly being requested appropriately for these families. Unlike general psychiatry, where liaison psychiatry is a subspecialty, liaison child psychiatry is part of the work of all child psychiatrists.

Research

There has been a vast increase in research in child psychiatry. The majority of teaching departments have active research programmes and these teams are led by consultants who will spend part of their time in this activity. One result of the research activity is to help us to recognise the ways in which some child psychiatric disorders can be prevented.

Prevention

In order to apply the results of research, consultants must go out into the community and, with their colleagues, set up preventive services. An important part of this work takes place in schools, nurseries, and in general practice, and there has been an increase in consultative services from child psychiatric departments to primary care workers in the community. In the long term, these services should reduce the need for clinical services, but at present they are costly in resources.

Administration

Child psychiatrists, like other consultants, must take their share of the administration and management of the NHS. It is essential that they attend the committees at which resources are distributed, but this takes time away from their other activities, and in districts where there is only one child psychiatrist, an unreasonable burden will fall on that consultant's shoulders. For example, he is likely to attend the Area Review Committee on child non-accidental injury, his Psychiatric Division, the Paediatric Division, NETCAP, University Board of Studies, as well as his departmental meetings. Many consultants spend some of their time in trying to raise funds to supplement their departmental budgets to enable staff to attend conferences and to finance the research of the department. Whilst this is encouraged by the present government, it makes inroads into the time of a single handed consultant.

Adolescence

The report of the Health Advisory Service *Bridge over Troubled Waters*[4] recommended that child and adolescent psychiatrists offered services for young people aged up to 19 years. At present most clinics do not offer services beyond school-leaving.

Inner city Problems

The higher prevalence of child psychiatric disorder in inner cities is now well documented,[5] (approximately double that in rural districts). College recommendations did not take account of this disparity.

Drug and solvent abuse

The age at which abuse of drugs begins has got steadily younger, so that this has become a problem seen and treated by child psychiatrists.

Social services work

As a result of closing children's homes, there has been an increase in requests from social services for advice and assessment of children in care in the community.

Changes in other related professions

It is likely that social workers will be withdrawn from the Health Service. Educational psychologists, who used to carry a clinical caseload, have been withdrawn from psychiatric clinics and do virtually no therapeutic work. These changes have implications for child psychiatrists who have to carry on the bulk of treatment.

Recommendations

We recommend that NETCAP Region increases its establishment of child and adolescent psychiatrists in

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line with 1983 Royal College recommendations. This will involve the immediate creation of at least 12 extra consultant posts. In addition it should review the demands on services, district by district, and evaluate the need for extra help for districts with special needs (inner city, widely dispersed populations etc.)

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Addendum

This report was prepared for, and approved by, the NE Thames Regional Psychiatry Advisory Committee who recommended that it was published in order to encourage other Regions to examine their consultant child psychiatric establishment and consider measures to deal with any shortfall discovered. Districts which are inadequately staffed are already finding it difficult to attract high calibre consultant applicants for posts.

The abuse of drugs

DAVID BERESFORD, MDU Secretariat

Recent Government policy has encouraged initiatives aimed at preventing the spread of drug misuse and improving treatment for those who already suffer the effects of dependence. There are probably up to 100,000 opiate addicts in the UK and dependence on prescribed drugs such as benzodiazepines presents a problem of increasing medico-legal significance. All doctors have a responsibility to ensure that drug misusers are offered treatment and should be prepared to assist them with withdrawal from drugs if requested to do so. Many doctors still fight shy of becoming involved, often through fear of contravening the controlling legislation.

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The Misuse of Drugs Act 1971

Before the 1960s the control of addictive drugs was largely confined to restrictions on the use of opium and cocaine. With the 'hippie' era came extensive use of 'recreational' drugs such as cannabis, amphetamines and LSD, and their consequent control by the Drugs (Prevention of Misuse) Act 1964 and the Dangerous Drugs Act 1965. As opiate misuse became more and more widespread, legislation was consolidated and improved in the Misuse of Drugs Act 1971 which remains the basic statute in force today.

This Act tightened the regulations relating to the possession and supply of drugs of dependency. However, it was recognised that doctors should be able to treat their patients appropriately without being hindered by the prohibitions of the Act and Section 7 in particular defines the lawful uses of 'controlled'