a child psychiatrist in the screening would allow for the detection and follow-up of problems in individual children (Vanharen & La Roche, 1993). As part of routine history-taking, the presence of children should be recorded in the index patient's case notes.

Basic screening of the needs and welfare of these children should be documented by the adult psychiatric team. Where children are vulnerable, child protection procedures should be initiated via referral to the relevant children and families team in social services.

Closer liaison between adult psychiatric teams and child and adolescent psychiatric teams should be encouraged in order to identify and prevent further damage to children at risk. A prospective research project to detect children of mentally ill parents and to offer an intervention project for their children has been started in Redbridge.

To work in accordance with the spirit of the Children's Act 1989, inter-agency cooperation in providing services for these children in need and their protection should be undertaken. A health professional may be the person to bring a problem to light and express the need for an assessment if there is concern about the child. Court orders under the Act (assessment, protection orders, etc.) can be issued when significant harm is suspected or for a child to be made safe.

Nevertheless, the spirit of the Act is that the best place for the child to be brought up is usually in his/her own home. Therefore, greater collaboration between mental health professionals, parents and their children in meeting their needs would be necessary.

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Making sense of child and adolescent mental health services

Paul Stallard and Robert Potter

Aims and method A prospective audit of the 425 referrals made to a community child and adolescent mental health service over a three month period was undertaken. Standardised data were collected about the referrer, reason for referral, problem chronicity and complexity, service response and first appointment attendance.

Results The service is currently seeing less than one in five of the children conservatively estimated to require specialist mental health services. The majority of those

referred were appropriate, identifying multiple problems of longer than six months' duration presenting within a complex context.

Clinical implications The results have provided commissioning authorities with a clear specification of the current service. This can inform decisions about resource reallocation, prioritisation and future service development. Clinicians feel that the complexity of their work is now understood and various audit projects and initiatives have been established in order to explore alternative ways of responding to referrer demands.

The past few years have seen the publication of a number of influential reports which have raised the profile of child and adolescent mental health services (CAMHS) and placed them increasingly higher on the agenda of commissioning authorities and service providers (Department of Health & Department for Education, 1995; NHS Advisory Service, 1995). The need for CAMHS is potentially very large with some estimates suggesting that at any one time up to 20% of children present with a diagnosable mental health disorder. Not all of these children require specialist help because a number present with transient difficulties. Others will be unwilling to accept or do not recognise the need for specialist intervention whereas others will be appropriately helped by other professionals, particularly health visitors or school nurses. This has led some researchers to revise these estimates and suggest that approximately 9% of children present with psychological difficulties which need the attention of a specialist CAMHS (Kurtz, 1996). The number of children actually seen by CAMHS is much lower than this conservative estimate, but even at this level the capacity of the service to effectively respond has been severely challenged. CAMHS are in crisis, characterised by demoralised clinicians, growing waiting lists, increasingly narrow prioritisation of referrals and mounting concerns about inaccessible and unresponsive services.

A service model to aid commissioners and service managers detailing a framework for a comprehensive CAMHS has been proposed (NHS Advisory Service, 1995). While this model is helpful in identifying the different levels of service delivery it does not provide purchasing authorities with clear ideas as to whether it can be operationalised within existing resources. For the majority of services there is a chasm between this ideal model and the current situation where CAMHS are poorly resourced and where purchasing authorities have limited funds to invest.

Because the possibility of significant new investment in CAMHS is limited, commissioning authorities and service managers have turned to examining whether existing resources are appropriately targeted and being used effectively. This issue was highlighted in the national survey where it was concluded that CAMHS had developed historically and did not necessarily reflect need (Kurtz *et al*, 1994). Attempting to clarify this issue is complex and can generate tension between clinician, service manager and commissioner.

Within this context it is easy to see why clinicians feel devalued and overwhelmed and why many CAMHS managers feel paralysed and unable to plan or identify ways in which the service can be moved forward. However, a central problem for CAMHS is that the service is often difficult to quantify and is poorly understood. There are differing expectations as to what the service can or should provide and the perpetuation of beliefs or myths that the service is inefficient or not targeted upon the most needy children.

The study

In 1996, Bath Mental Health Care Trust (BMHCT) undertook a review of CAMHS. The review was precipitated by an increased demand with the annual referral rate rising over four years from 1500 to over 1750 without any proportional increase in clinical staff. A joint project with the Audit Commission provided information as to how clinical staff spent their time, and in particular the balance between direct client contact and indirect work (i.e. case note administration, case liaison, supervision, consultation, training etc). The review concluded that the next step was to clearly define what the service was currently providing. Achievement of this objective would help to determine whether the service was focused on the most appropriate children. It would also provide a rational basis upon which to propose any re-targeting of resources and a clear understanding of the effects of this on existing provision.

The Chief Executive commissioned a project, led by the authors, two senior clinicians within CAMHS, to audit in a systematic way the work undertaken by the service. The purpose of the project was to determine whether CAMHS was targeted upon those children with chronic, long-standing, multiple problems presenting within a complex context which may adversely affect their responsiveness to change. The underlying assumption was that these are the children most in need of CAMHS.

The proposed project was discussed with each professional group, the four community teams, the district-wide specialist service for young people and CAMHS management and planning groups. An audit form collecting information on each service user referred to CAMHS over a three-month period was developed, discussed,

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revised, piloted and agreed. Basic demographic information and standard data about the referrer, reasons for referral, problem chronicity and complexity, service response and appointment attendance were collected. All clinical staff participated in the audit and completed audit forms for 413 of the 425 referrals made over the three-month audit period were returned and analysed. Each team received their own local information as well as a summary of the complete data for the whole service.

Findings

What percentage of the local population are referred to CAMHS?

A four-tier service model of CAMHS has been proposed and is widely accepted as a blueprint of a comprehensive CAMHS (NHS Advisory Service, 1995). The percentage of children who need specialist services at each tier has been estimated (Kurtz, 1996). A total of 8.85% are thought to present with moderate, severe or complex problems that need the help of an individual professional (Tier 2) or a number of professionals (Tier 3) trained in children's mental health. The audit demonstrated that the Bath service is currently seeing 1.88% of children, approximately one in five of those children estimated to require specialist Tier 2 and 3 interventions.

A further 0.075% present with the most serious, persistent and complex problems that require highly specialist (Tier 4) services. The local service is providing Tier 4 services to 0.063% of the population.

These results highlight that the service currently sees only a small proportion of those children conservatively estimated to require the input of the CAMHS. In view of this it was important to ascertain whether those children currently referred to the service are those most in need and this led the audit to explore the second question.

Is the service seeing the right children?

The audit provided an opportunity to investigate this question in a number of ways.

Do children referred to CAMHS have long-standing problems? Limited therapeutic resources should be primarily focused upon children with chronic problems. Although early intervention can be important transient difficulties may not require the involvement of a specialist service and short-term problems can often be helped by other health care professionals.

The audit demonstrated that 76% of referrals were for long-standing problems that had been present for six months or longer. Only 5% presented with problems of recent onset (i.e. less than four weeks) and of these, two-thirds were appropriate, relating to referral problems of deliberate self-harm or attempted suicide.

Are children and families referred with multiple problems? In the majority of cases CAMHS should be focused upon those children presenting with multiple problems. Single problems may not require specialist mental health services and may be helped by other professionals.

Almost two-thirds of referrers (63%) highlighted multiple difficulties identifying three or more problems. After excluding those referrals that were rejected as inappropriate or those that identified problems of deliberate self-harm or attempted suicide the service saw only 38 (9%) single problem referrals.

Do these problems occur within a complex context? There is clear evidence that various environmental, medical and social factors increase the likelihood of child mental health problems developing and adversely affect their responsiveness to treatment (Wallace *et al*, 1995). It is therefore important to ensure that referrals presenting within a more complex environment are seen by CAMHS.

Information about complexity was obtained for 305 of the referrals and the frequency with which they presented is summarised in Table 1.

On average each referral was accompanied by two complexity factors. Negative family factors such as extreme marital discord, domestic violence, family breakdown, etc. were most common and were identified in half of the referrals. Difficulties at school and other professionals and agencies being involved were also frequent and highlight the considerable degree of liaison and professional networking required in order to coordinate work with these referrals.

On the basis of these criteria it would appear that the majority of the referrals to the service were for children with chronic, multiple problems

Table 1. Percentage of referrals to CAMHS identifying each complexity factor

Parental mental illness	18%
Parental criminality	3%
Significant negative family factors	50%
Other professionals involved	32%
Other agencies involved	24%
Child has a chronic health problem	9%
Child has significant difficulties at school	39%
Social services involved or a child protection investigation in the past six months	11%
Overcrowding or homelessness	3%
Significant financial worries	9%
Unemployment	5%

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presenting within a complex context. In order to understand more about the specific problems referred to CAMHS the audit addressed the third question.

What problems are referred to CAMHS?

The audit used a standard checklist to categorise referral problems. This had been developed over many years by one of the local teams and was accompanied by a detailed directory providing further descriptions of each category. On the basis of the information in the referral letter the clinician marked which problems were identified by the referrer as the reason for referral to CAMHS. The problems were also categorised after the first appointment with the child or family and this confirmed that the majority of referrers had identified problems appropriately. A summary of the number of times each problem was identified is shown in Table 2.

The most frequently identified difficulties were for school related problems, managing a child's challenging behaviour and concerns about aggressive, violent and angry outbursts. The detrimental effects of parental separation upon the child and concerns about unhappiness were also common.

The large number of referrals highlighting school based problems raised questions as to whether these were appropriate referrals for CAMHS or whether these children should have been referred to the education department. Further analysis revealed that none of the children were referred with a single school based problem. The majority presented with multiple problems and the presence of difficulties in school was an indication of the pervasiveness of the difficulties.

Are existing resources being used efficiently?

Once the type of work undertaken by the service became clear it was then possible to begin looking at how efficiently the current resources were being used. There are many ways in which this question could be explored and the audit decided to focus upon first appointment non-attendance. It is important that wasted clinical time due to appointment failure is kept to a minimum thereby maximising the use of limited clinical assessment slots. The first task was to determine the overall rate of first appointment failure and then to explore whether there were factors that were associated with non-attendance. The audit found that although approximately one in five families did not attend their first assessment interview almost half contacted the service to cancel the appointment. In only 11% of cases were planned assessment

Table 2. Frequency of problems referred to CAMHS

	Identified problem	Total
A.	School related problem	136
	School non attendance	28
	Language/speech problems	14
	Learning difficulties	33
	Medical condition	36
B.	Aggressive/violent/angry	93
	Defiant non-compliant	51
	Management of behaviour	115
	Overactive	37
	Sleep	43
	Soiling	19
	Tantrums	24
	Wetting	21
C.	Anxious/timid/clingy	30
	Bereavement/loss	23
	Depression	39
	Fears	32
	Irritability/moodiness	25
	Rituals and habits	10
	Somatic symptoms	23
	Solitariness	8
	Upset/unhappy	71
	Withdrawn	20
D.	Criminal delinquent	6
	Drug/alcohol/substance abuse	16
	Lying	5
	Running away	8
	Stealing	10
E.	Inappropriate sexual behaviour	6
	Suspected abuse	
	sexual	8
	physical	2
	emotional	2
	Disclosed abuse	
	sexual	14
	physical	8
	emotional	3
F.	Anorexia nervosa	2
	Other eating problems	27
	Bizarre/unusual behaviour	7
	Psychotic problems	5
	Deliberate self-harm	45
	Suicide attempt	13
G.	Contact arrangements	21
	Adoption issues	6
	Adult focused problems	55
	Adverse social circumstances	15
	Parent/child relationship	67
	Parental separation/family breakdown	73
	Partner conflict	16
	Peer relationships	37
	Sibling relationships	34
H.	No problems	4
	Other	17
	Average number identified	3.56

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slots unfilled and there was nothing in the information available at the point of allocation to differentiate service non-attenders from those who attended.

Comment

The limitations of this audit are acknowledged. The results are dependent upon the information provided by referrers and on clinicians completing audit forms in a consistent and comprehensive way. The problems referred may not necessarily be the focus of the work undertaken by CAMHS and often other problems emerge during the course of therapy. The audit has also undertaken a very pragmatic approach and has not attempted any social profiling nor focused upon matching indices of deprivation with referral patterns. Finally, in the absence of any comparable data it is not possible to determine whether these results are representative of other services.

Despite these limitations the audit has provided a wealth of information that has been helpful for clinicians, service managers and commissioning authorities. The results have been warmly welcomed by clinicians who feel that the complexity of their work is now better understood and their contribution valued. This has prompted a number openly to question and scrutinise their work resulting in the initiation of a number of separate audit projects. The service is more visible and more easily understood enabling service managers to examine how resources are currently allocated and to clarify purchaser expectations. The process has also facilitated change and has enabled teams to explore alternative ways in which they can respond to referrer demands. A summary of the audit has been sent to each commissioning authority providing them with a clear specification of the service they are currently commissioning. This in turn will provide an objective basis for future discussions about service priorities thereby enabling rational decision making about the use of existing resources. Finally, the audit has identified various shortfalls and the results may facilitate future developments and joint commissioning of services.

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Accuracy of references in psychiatric literature: a survey of three journals

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Aims and method The prevalence of errors in reference citations and use in the psychiatric literature has not been reported as it has in other scientific literature. Fifty references randomly selected from each