appointment, or special interest basis, should have held a Senior Registrar or equivalent academic post in such a training scheme normally for a period of three years.

For a joint appointment in child and adolescent psychiatry and mental subnormality the Senior Registrar training period should normally be for at least three years with specific experience in the psychiatry of mentally handicapped children in both hospital and community settings.

(d) *Forensic Psychiatry*

The basic training in general psychiatry should have been followed by experience in forensic psychiatry, in a Senior Registrar or equivalent training post, normally for a period of three years. Experience in a related field should be given due weight.

(e) *Psychotherapy*

The basic training in general psychiatry should have been followed by specialist training and experience for a period normally of three years in the practice of psychotherapy preferably in a Senior Registrar training post.

(f) *Psychiatry of Old Age*

Basic training in general psychiatry, which should have included training in the psychiatry of old age, should be followed by at least one year of experience in this field during the Higher Professional Training period.

(g) *Consultants in General Psychiatry with a Special Interest in a Named Specialty*

Posts are often advertised for consultants to work in general psychiatry with a 'special interest' in one of the following subjects—alcoholism and/or drug addiction; rehabilitation; the psychiatry of old age; liaison psychiatry; behavioural treatments; mental handicap; forensic psychiatry; psychotherapy; and adolescent psychiatry (child *and* adolescent psychiatry cannot, however, be a special interest subject for a general psychiatrist). Candidates for such posts need to have had substantial experience both in general psychiatry and in the special interest subject.

Candidates should also have spent at least one year of their higher training in a conventional general psychiatric post and, as in the case of other consultant posts, should have completed three years of higher training altogether. If an otherwise well qualified candidate has had insufficient experience of the special interest subject a proleptic appointment may be recommended, provided the Advisory Appointments Committee has an assurance that the candidate will be given the opportunity to acquire the requisite experience immediately after taking up the post (see p. 2, para 6).

(h) *Special Hospitals*

While most consultants in Special Hospitals will be fully trained forensic psychiatrists, those trained in general psychiatry or in mental handicap with a special interest in forensic psychiatry could well contribute to the work of a Special Hospital. The special interest in forensic psychiatry would be recognised in the terms already defined by the College, i.e. at least one year's experience in forensic psychiatry. However, it may be that a suitable candidate, trained in general psychiatry or mental deficiency, but without any, or enough experience in forensic psychiatry, and wishing to develop such an experience, could be offered a proleptic appointment by the Advisory Appointments Committee. He/she would be expected to acquire the necessary experience as soon as possible after taking up the appointment. On making such an appointment the need for the Special Hospital to have substantial consultant cover by forensic psychiatrists must be borne in mind.

The Role, Responsibilities and Work of the Child and Adolescent Psychiatrist

Introduction

This paper, produced by the Child and Adolescent Specialist Section of the Royal College of Psychiatrists, is a revised version of the document of the same title published in the *Bulletin* in 1978[1].

Its purpose is to describe the role of the child and adolescent psychiatrist today. In what follows 'child psychiatrist' will generally be used to mean 'child and adolescent psychiatrist'.

1. **Training and appointment of a consultant child and/or adolescent psychiatrist**

A consultant child psychiatrist is a qualified medical practitioner. Following pre-registration and other house officer jobs, general professional training takes place, which is normally a three-year preparation for the examination for the Membership of the Royal College of Psychiatrists (MRCPsych), and in some cases a

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university degree such as the MPhil or other higher medical qualifications.

General psychiatric training provides experience in diagnosis and management of adult psychiatric patients in different settings and using a variety of therapeutic skills. All trainees should have had experience and training in research methods, and many carry out research projects. At this stage, the trainee is introduced to the specialties, including child psychiatry, mental handicap and forensic psychiatry. Higher specialist training in child psychiatry takes place at senior registrar level and lasts three to four years. Training is both theoretical and practical and the post has to meet the approval of the Joint Committee on Higher Psychiatric Training and the Royal College of Psychiatrists. The trainee's work, supervised by a consultant child psychiatrist, develops so that by the end of training s/he should be capable of organising a comprehensive child psychiatric service.

Appointment to the post of consultant child psychiatrist in the National Health Service is by open competition. The Advisory Appointments Committee includes other consultants in the same field and representatives from Universities and Health Authorities. An assessor from the Royal College of Psychiatrists who is employed in a different region advises on the standard of training of the applicants[2]. A guideline for approval for training programmes has been issued by the Joint Committee on Higher Psychiatric Training[3].

2. The responsibilities of a consultant child and/or adolescent psychiatrist

(i) *Clinical responsibilities*
The clinical services include:

(a) Diagnostic assessment.

(b) Treatment of children and families.

(c) Consultation to other professionals concerned with the care of children, such as general practitioners, clinical medical officers, paediatricians, health visitors, workers in day nurseries and community homes, teachers in ordinary and special schools, social workers and foster parents. This may or may not involve assessment of an individual child.

(d) Formal assessment and provision of reports for Education and Social Services.

(e) 'Medico-legal' work may involve the provision of reports or legal advice to a Court as an expert witness, advising probation and conciliation services, on matters concerned with children's welfare, juvenile delinquency, child abuse, access and custody, and adoption and fostering.

(f) Prevention: it is desirable that child psychiatrists be involved in the prevention of avoidable mental and emotional distress and possible long-term harm by advising staff in neonatal and paediatric wards, community homes, nurseries, schools, social workers, etc., as well as parents and foster-parents.

(ii) *Administrative responsibilities*
Responsibilities vary according to setting and it is important that they should be clarified. The Court Committee[4] recommended that child guidance clinics and hospital departments of child psychiatry should be 'recognised as part of an integrated child and adolescent psychiatric service, which includes clinics in a variety of settings and with varying emphasis, all of which apply the same body of knowledge'. With the reorganisation of the NHS of 1982 it is even more clear that child psychiatrists should be involved in organising and developing coherent and comprehensive child and family psychiatric services appropriate for the needs of their districts.

The consultant should:

(a) seek to ensure that children and families referred to the clinic are diagnosed and treated with appropriate and efficient use of available resources;

(b) facilitate good communication within the service and within the community by ensuring especially that appropriate letters and reports are sent to doctors and other referral agents and by participating in formal and informal meetings with appropriate professional and voluntary agencies;

(c) seek to ensure the maintenance of confidentiality;

(d) collect appropriate information for the monitoring of current services and evaluation of new methods;

(e) attend or be represented at District and other appropriate committees, such as the local division of psychiatry, for administration and planning, to secure appropriate resources and improve facilities.

(iii) *Teaching responsibilities*
Whilst the consultant may have teaching responsibilities in relation to other professional groups, it is recognised that s/he has particular responsibilities towards trainees in general psychiatry. The other professional groups may include medical students; trainees in child psychiatry; trainees in other medical specialties, especially paediatrics, general prac-

tice and community health; nurses, health visitors and others concerned with the care of children; trainees in social work, clinical psychology, child psychotherapy, occupational therapy and speech therapy. Wherever possible, there should be close contact with appropriate university departments.

(iv) *Continuing education*
Time for attendance at professional meetings and conferences should be a matter of contractual obligation.

(v) *Research and development of the specialty*
Child psychiatrists have a responsibility to help to develop the scientific basis of the specialty and also to contribute to the continuing evaluation of clinical practice.

3. How should a child and adolescent psychiatrist apportion her/his time?

(i) When a consultant psychiatrist's time is being organised, the following considerations should be noted:

(a) Surveys show that at any one time between 5 and 25% of children have a psychiatric disorder, but only a small proportion of these children are referred to child psychiatric or child guidance clinics.

(b) There is also wide variation in the distribution of child psychiatric and other resources. An acceptable level is suggested in Section 4.

(c) Good practice offers a range of services, resources and techniques to help children and families.

(d) The process necessary for diagnostic assessment and therapeutic work can be very time-consuming.

(e) Responsibility for teaching graduates and undergraduates varies.
Consultants will give an appropriate proportion of their time to three aspects of their work:
1. Direct contact with children and families
2. Consultation
3. The activities mentioned in Section 2
Proportions of time spent on each may well vary with the nature of the post and changing circumstances.

(ii) *Allocation of sessions*

(a) It is the accepted policy of the Royal College of Psychiatrists and the DHSS that all consultant child psychiatrists should have a hospital appointment and sessions allocated there even though other sessions may be spent elsewhere such as in a community clinic or assessment centre.

(b) Where new diagnostic and treatment services in child psychiatry are being developed it is preferable that these are placed in Health Service premises, to simplify issues such as accountability, confidentiality and the ownership of notes.

(c) It is desirable that sessions are not permanently fixed at particular establishments, e.g. a children's home or special school, as needs may vary from time to time. It is preferable for so many sessions to be made available for consultative work with other agencies, especially Education and Social Services, and for the consultant to negotiate the details of the arrangement. From time to time the priority of allocation of the sessions themselves may also need to be re-negotiated within the Health Authority according to the needs of the district.

4. Facilities required to fulfil responsibilities

(i) *Staff for child and adolescent psychiatric service*

(a) *Consultant child psychiatrists*
The College has recommended that as 'an irreducible minimum' two WTE child and adolescent psychiatrists are needed for a total population of 200,000, three being desirable, with extra provision for Teaching Authorities and regional special services such as in-patient adolescent units serving more than one district[5].

(b) *Junior medical staff*
It is particularly important for there to be available junior medical staff in child psychiatry.

(c) *Non-medical professional staff*
The quality of work is enhanced by the attachment to the Child Psychiatric Service of social workers, clinical and/or educational psychologists, child psychotherapists, psychiatric nurses and specialist teachers. It is desirable that the psychiatrist be able adequately to influence the selection of the other professional staff, or at least be satisfied with their professional standards. It is helpful when the same individuals work together from the same premises regularly in order to achieve cohesion as a team, provide continuity of treatment and afford opportunities for interdisciplinary training.

(d) *Secretarial staff*
It is essential to have a good secretarial service for administration, reception, dealing with case notes, all communications and practical arrangements. Other agencies requiring consul-

tation (such as in a Social Services assessment centre) should provide secretarial support, but it is essential for a consultant child psychiatrist to have a secretary provided by the NHS who should be of at least HCO grade. In non-NHS settings the consultant's employing authority must be able to ensure that the secretarial services provided are sufficient and appropriate and that medical confidentiality is upheld. This may necessitate NHS input into the administration of the secretarial service with representation on appointments and a say in how the service is delivered.

(ii) *Environment*

Whether the clinics are in-patient or out-patient, in hospital or community, they need to be easily accessible and to contain large and small interview rooms and offices which are sound-proofed sufficiently to protect confidentiality. When furnishing, the emphasis should be on a relaxed, welcoming atmosphere. Equipment for medical examination should be available. Waiting rooms, locked cabinets for notes and dictating facilities are essential; audio and/or video recording facilities and one-way screens are also desirable. Play material is an essential diagnostic and therapeutic tool requiring constant replenishment. There should be a specific room designated for the use of each consultant child psychiatrist.

(iii) *Access to other medical services*

Direct access to full medical diagnostic facilities is essential, as is easy access to specialist paediatric and adult psychiatric consultation. Child psychiatrists may need to admit children to hospital, either to a paediatric ward or to a special psychiatric in-patient or day-patient unit for children and/or adolescents, so access to such facilities should be defined, whether they are available in the same Health District or not.

(iv) *Access to other facilities*

Equally important is access to a full range of post-graduate educational and library facilities, seminar rooms and lecture theatres.

5. **Referral**

Child psychiatrists have traditionally accepted referrals from a range of professionals, and from parents. The GMC[6] advises that 'a specialist should not usually accept a patient without reference from a patient's general practitioner. If a specialist does decide to accept a patient without such reference, the specialist has a duty immediately to inform the general practitioner of his findings and recommendations before embarking on treatment, except in emergency, unless the patient expressly withholds consent or has no general practitioner.' However, 'in some areas of practice specialist and hospital clinics customarily accept patients referred by sources other than their general practitioners. In these circumstances the specialist still has the duty to keep the general practitioner informed'.

6. **Forms of medical relationship and confidentiality**

The doctor's primary duty is to her/his patient, and especially with children, to those who have the legal care of the patient (e.g. the parents, legal guardians, Social Services). The BMA *Handbook of Medical Ethics*[7] describes three forms of medical relationship: first, the normal therapeutic doctor/patient relationship; second, examination for a third party and third, research.

In child psychiatry the second form of relationship is relatively common, often as assessment for Social Services, a Court of Law, or Education. It is essential that the nature of the relationship is explained to the child and family and that consent is gained for both the assessment and for the transmission of information, where the examination is not compulsory. Assessment under the Mental Health Act (1983) may also became more common.

The maintenance of confidentiality in child psychiatry is often a delicate issue as much work is done in close collaboration with non-NHS professionals and agencies. The GMC[6] advises that: 'It is the doctor's duty strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient. Exceptions are made when the patient or his legal adviser gives consent; or the information is required by law; or if, in the doctor's opinion, disclosure of confidential information to a third party other than a relative would be in the best interests of the patient.' The most recent GMC Guidance (February, 1986) is that the doctor also may disclose information to parents of young people under 16, informing the patient accordingly: 'His judgment concerning disclosure must always reflect both the patient's best medical interest and the trust the patient places in the doctor.'

This is not a static situation as a new climate of opionion is emerging which favours the concept of extended confidentiality relating to a wider team of workers based on the principle of the need to know in the interests of the child. Nevertheless, care must be taken to safeguard the confidentiality of recorded information and rights of access between disciplines needs to be clearly defined, especially when these are across agencies[8]. In this respect the College agrees with the

recommendations that a Health Authority should negotiate formal written confidentiality policies with a local Authority. These should ensure that all workers who have access to data are bound by the same standards of confidentiality; access to patient data does not extend beyond professional staff (e.g. to local authority councillors); and that there are agreed procedures when allowing client access to social work records. Unless there is a strong reason, health derived information should not extend beyond the social worker responsible for hospital services.

The child psychiatric team: clinical responsibility and organisational relationships

A consultant child psychiatrist in the NHS has clinical autonomy, with consequent legal, professional and ethical obligations. This means that s/he is able to pursue her/his professional practice as s/he thinks best provided s/he stays within certain broad limits of professional ethics, and s/he cannot be directed clinically. In other respects s/he is responsible to his/her employing authority.

Whilst in hospital services the consultant is clearly seen as the clinical leader of the team, this is less clear in some community child guidance centres, especially where other professionals concerned are not employed by the NHS. Considerable time and effort has been spent in the last few years examining and clarifying the respective roles of professionals in 'Child Guidance'; see for instance the Brunel working paper '*Future Organisation in Child Guidance and Allied Work*'[9] and the Report of the Interdisciplinary Working Party, *'Interdisciplinary Work in Child Guidance'*[10]. In response to the latter the Child Psychiatry Section of the Royal College of Psychiatrists held that where a child and adolescent psychiatrist is offering diagnostic and treatment services, prime responsibility for monitoring and co-ordinating the needs of the service as a whole should rest with the consultant in order to best serve the needs of the patient.

However, in non-NHS settings such as a children's home or a school a consultant child psychiatrist can offer an assessment and/or consultation service only. Where the psychiatrist does not carry out clinical work, s/he must make it clear that s/he is there to advise staff and is not responsible for the clinical care of children about whom consultation is sought.

In intermediate situations such as in child guidance settings not administered by the Health Authorities the consultant must make it clear that in cases which are referred to him/her, and in others over which he or she is consulted, s/he needs to have some continuing oversight until the children are discharged from the clinic. Other cases that are not referred to him/her and that s/he is not consulted about are not part of his/her responsibility[11].

It is therefore essential that the Consultant Child Psychiatrist should clarify with the Health Authority on appointment the nature and extent of his/her clinical responsibilities, and the responsibility for monitoring and co-ordinating the Child Psychiatric Service and that the arrangement must allow him/her to fulfil her/his roles and duties as outlined. This will necessitate there being a clear administrative structure within each Health Authority (such as a Unit of Management) to which the child psychiatry service as a whole can relate. There also need to be clearly established administrative mechanisms through which the collaborative services are organised, as recommended in HN(82)9, *National Health Service Restructuring: Collaboration between the National Health Service and Local Government*[12].

Approved at Council March 1986

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ADDENDUM

Contraception and the young

The reader is advised to take note of the continuing debate on this issue by the BMA and GMC and particularly the recent DHSS guidance outlined in their circular of March 1986 (HC(86)1: HC(FP)(86)1: LAC(86)3) and the attached CMO/CND letter.