The College

Providing a District Service for Child and Adolescent Psychiatry: Medical Manpower Priority

(Report of the Child and Adolescent Psychiatry Section)

Purposes of this paper

This paper considers the possible long-term consultant manpower requirements in England and Wales for child and adolescent psychiatry and its specialties, including psychotherapy and community child and adolescent psychiatry. It is based on papers previously prepared by the College Executive in relation to manpower requirements for child psychiatry (Royal College of Psychiatrists, 1973) and adolescent psychiatry (Royal College of Psychiatrists, 1976), and to the role, responsibilities and work of the child and adolescent psychiatrist (Royal College of Psychiatrists, 1978) and on discussions with the Department of Health and Social Security.

Consideration is also given to the training implications of these consultant manpower requirements. It discusses the possibility of growth in relation to the number of consultants in child and adolescent psychiatry likely to be available. It concerns itself with services both for children and adolescents. Although in previous College documents separate estimates were provided for these groups, we do not believe any useful purpose is thereby served, and we propose to offer combined estimates. It is, however, necessary to define adolescence, and we use the definition adopted in the *Bulletin* (Royal College of Psychiatrists, 1976), namely the period from 12 to 18 years. It is evident there will be an overlap with children and children's services at the lower end, and young adults and adult services at the upper end.

Comment on manpower trends

The increase in child and adolescent consultant whole-time equivalents (wte) in NHS psychiatric posts over the years 1970–81 averaged 8 per cent per year (i.e. 143 wte to 278 wte), and the number of senior registrars increased by over 9 per cent per year (i.e. 37 to 84). The absolute number and their wte are shown in Table I. Established consultant posts now number 374 (334 wte), but vacancies number 62 (58 wte).

College suggestions for providing a District Service for children and adolescents

The DHSS has already indicated that their initial aim for better services for the mentally ill was a ratio of one wte consultant in child and adolescent psychiatry for a population of 200,000. This level has already been achieved nationally. It is clear that there is still a grave deficiency of services. A good service demands a greater number of psychiatrists in the light of considerable change in services and increasing therapeutic effectiveness. For instance, the advent of family therapy now enables psychiatrists to tackle problems of childhood and adolescence which were previously insoluble. From this total manpower pool, provision must be made for psychiatric services to hospitals, services in the community (community homes, social services, etc.) and to special settings (including the new district and regional observation and assessment centres, the courts and the child develop-

TABLE I*

Child and Adolescent Psychiatry—England and Wales—Population 49,185 (thousands)

	Total staff	Wte staff in post	Per 100,000	Place of birth UK	Males	Age					
						35	40	50	55	60	60
Consultants	312	(278)	.64	234 (209)	193 (177)	14	46	104	43	48	23
Associate specialist	3	(2.5)									
Senior registrars	84	(74.0)	.17	53 (45)	47 (46)	36	24	11	3		
Registrars	25	(23.0)	.05	11	14	Not stated					
SHOs	3	(2.4)		NS	NS						
Para. 94 appointments	57	(16.4)									

* Extracted from *National Tables Hospital Medical Staff: England and Wales: 30 September 1981.*

( ) = wte; NS = not stated. Figures do not include 20 Transfer Consultants.

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ment and comprehensive assessment centres staffed by paediatricians, and others in the District Handicap Team) and, of course, for teaching, training and research. There are particular deficiencies in provision in the case of regional and national psychiatric services to adolescent units, secure units and assessment units and to units for autism and deaf children. For these reasons it is our belief that current provision is too low.

The College previously recommended a realistic minimum of 1.5 child psychiatrists per 200,000 population (1973) and a further 1 per 500,000 for adolescence; similarly, an ideal of two for child psychiatry and one for adolescents for the same population. The following tables have been prepared from DHSS statistical documents and College memoranda recommending manpower needs for child and adolescent psychiatry separately. They present the overall implication of these recommendations and, furthermore, indicate the patterns of service for an average district (Tables I, II, III and IV).

TABLE II
Staffing—actual and estimated: Staff in post—England and Wales, 1981

	1958	1970	1977	1981
A. Consultants	128 (?)	183 (149)	248 (218)	312 (278)
B. Transferred consultants	?	43 (34)	78 (25)	
Total A + B	128 (?)	226 (183)	326 (243)	312 (278)
C. Senior registrars	(10)	(37)	83 (75)	84 (74)
D. Registrars	?	(12)	26 (24)	25 (23)

( ) wte.
A+B for 1977 and 1981 are minimal numbers.

TABLE III
Established posts and vacancies, 1981

	Consultants	Senior registrars
Established posts	374 (336)	94 (84)
Vacancies	62 (58)	10 (10)
Per cent vacancies	17%	11%

( ) = wte.

Is the balance right?

If there is to be fuller provision of whole-time equivalents of child and adolescent psychiatrists for a district of 200,000 people, serious consideration must be given to the balance between various sub-divisions of child and adolescent psychiatry and to the additional staffing required to meet the needs of specialist regional services. At present the national

TABLE IV
Estimates of need of consultants based on population of 49 million

Previous DHSS	1 per 200,000	245
Previous RCPsych (1973)	*Realistic minimum:* 1½ per 200,000 Child 1 per 500,000 Adolescents	475
Previous RCPsych (1973)	*Ideal level:* 2 per 200,000 Child 1 per 500,000 Adolescents	588
Current recommendations (1982)	*Irreducible minimum:* 2 per 200,000	490
Current recommendations (1982)	*Realistically desirable:* 3 per 200,000	735

average of consultants in post in child and adolescent psychiatry is 1.1 per 200,000 population. This does not take into consideration the balance between child and adolescent psychiatry both in hospital and community, psychotherapy and newer approaches such as family psychiatry and its extensive contribution to family illness, Local Authority services, services to secure units, etc. It is against such a background that the Department and College need to continue to give special consideration to the minimal and desirable rates to accommodate the development of such special interests. And also the DHSS has stressed the importance of joint planning so that the Health Service give full consideration to Local Authority needs for psychiatric provision.

Estimates of need

From our deliberations we have come to the conclusion that at an irreducible minimum we need two child and adolescent psychiatrists for a population of 200,000. This should be the next target in attempting to establish a comprehensive service to cover all the special areas of interest. It needs to be emphasized that the role of the child and adolescent psychiatrist has increased considerably over the last five years, in many areas previously overlooked, and especially in relation to family psychiatry. He also has an increasing role in relation to all sorts of handicaps in children, including mental handicaps and to the whole range of new assessment and child development centres. For these reasons we consider that a realistic desirable level should be 3 per 200,000 population. However, the staffing of regional and supraregional units needs to be additional to this suggested allocation. As child psychiatry attracts a higher proportion of doctors with local or personal commitments there is also a need for more part-time posts. Such recommendations are broadly in line with recommendations in other reports.

The acquisition of special skills has resulted in increasing demands on the consultant to make a contribution to a large

number of disparate services. It is therefore essential that we appreciate the importance of not fragmenting services in order to allow the development of special interests. This implies the need for more than one child psychiatrist for a particular population. The proposal for two consultants per district of 200,000 allows for geographical variation, since in rural areas one cannot easily plan services on population numbers, and in urban areas there is a need for more psychiatric help because of the endemic stresses of urban life.

Training implications

In order to plan for the growth of special interests it may be necessary to examine the balance of training in existing posts. It should be continually borne in mind that there will be a delay of some years between instituting a new training programme for senior registrars and an appointment of new consultants who have been through this training programme. The educational aspects of such senior registrar training posts are the concern of the Joint Committee on Higher Psychiatric Training, and also a matter for vocational training committees. This is because we must ensure that there is a sufficient supply of registrars to feed into senior registrar posts.

We understand there is currently an establishment for 84 whole-time equivalent senior registrars. However, there has not been a sufficiency of people exposed to child psychiatry at the registrar level to ensure the regular filling of all 84 posts. Child psychiatry must also take responsibility for contributing to the training of those heading for consultant posts in general psychiatry, posts in general paediatrics, posts in child psychiatry, posts in research and community medicine and general practice. Child psychiatry experience is desirable at registrar level otherwise, in his first year, the senior registrar may still be too junior to make an important contribution to teaching and clinical work. For such reasons we consider there should be an expansion of the senior house officer/registrar grade to allow rotation from psychiatry into child psychiatry.

However, there are reports that recruitment into child and adolescent psychiatry via rotational training schemes is not sufficient to fill the posts. It would therefore be valuable to have some degree of flexibility in the training route to the senior registrar grade so that certain posts could be made available to recruit from paediatrics or clinical medical officers who could spend longer than usual in the specialty. The establishment of a small number of additional senior house officer posts would produce a desirable degree of flexibility in training. Such senior house officers must be encouraged to subsequently seek registrar posts on accredited rotational training schemes to qualify them for the MRCPsych.

A number of other important issues need to be mentioned. The current level of senior registrars is relatively static, and this implies lack of growth. Nevertheless, recent documents provide evidence that there is an insufficiency of applicants for advertised consultant posts. Further, we believe that some expansion of the senior registrar grade is necessary. This view is supported by the following reasons: first, there is an inequitable distribution of senior registrars so that in some regions the possibility of recruiting new consultants from local training schemes is considerably reduced; second, child psychiatry attracts a large number of doctors with local or personal commitments who, for a while at least, drop out or reduce their commitment, or may need to take longer to complete a specified training. Provision needs also to be made for a greater permanent or temporary wastage than in other specialties (by immigration, domestic commitments or by taking posts in adult psychiatry), the late age at which many enter child and adolescent psychiatry (Table I) and the fact that for many the training begins at a senior registrar level.

It also has to be noted that consultant establishment has been expanded by those 20 whole-time equivalent 'transferred medical officers' who have been given consultant status, and since many of them are older, we must plan for their replacement, which implies again an expansion of the senior registrar grade.

Priorities

A distinction needs to be made between the larger number of established consultant posts and the smaller number of consultants in post. Although the national average of established child and adolescent consultant posts was about 1.4 per 200,000 population in 1981, the range varied from about 0.7 to 2.2. We would like to suggest that priority be given to the creation of new posts in areas at present undermanned. However, demands for new consultant posts are likely to exceed supply in the near future, thus making it difficult to fill some of the more peripheral posts. It must be emphasized that particular care needs to be taken not to deprive the central areas of staff while there is no possibility of filling peripheral posts.

Area Health Authority Teaching

We wish to draw attention to the marked lack of academic posts in child and adolescent psychiatry. The reasons for this are unclear. Some see this area as being mainly a postgraduate specialty, but those working in teaching hospitals report an increasingly heavy undergraduate teaching load. Others see this branch of psychiatry as a sub-specialty and cannot negotiate directly for academic developments. Whatever the explanation, child and adolescent psychiatry is poorly developed in terms of academic staff, and has to rely heavily on NHS personnel. It is therefore essential that in those Health Authorities which are recognized as Teaching Authorities there should be staffing provisions similar to that in general psychiatry and we suggest that a multiplication factor of 1.6 of that proposed for district services would not be unreasonable in the light of the current

circumstances. We estimate that this would give rise to the need for more than 20 to 25 additional whole-time equivalent consultant posts.

Conclusions

In 1981 there were 278 (whole-time equivalent) consultants in child and adolescent psychiatry in England and Wales—an average of about 1.1 per 200,000 population. We are now recommending minimally 2 per 200,000. There is a long way to go. Nevertheless, it needs to be pointed out that some districts already have two consultant posts per 200,000 population, while others have only 0.7. We understand there are now about 84 established senior registrar posts and this should allow an increase of 26 new consultants a year. At the current rate of progress, and taking wastage into consideration, we are likely to achieve the minimal rate recommended in 1973 by the College for Child and Adolescent Psychiatry in no less than some ten years from now (see Table IV).

It will be seen that the original long-term goal suggested by the College exceeded the DHSS long-term manpower aims and these are superseded by current estimates of need. We believe a good case can be made out for the current College recommendations, and hope the DHSS will review its longer term policy in the light of information provided in this document.

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Obituary

William Alan Swallow Falla, formerly Visiting Psychotherapist, H.M. Prison, Lincoln.

William Alan Swallow Falla, the last Medical Superintendent of St John's Hospital, Lincoln, died on 2 November 1982 at the age of 72.

He qualified MBBS in 1935 from Newcastle Medical School, then part of Durham University, having on the way played rugby for Northumberland County and rugby and cricket for the University. In 1939 he passed the DPM, in 1947 he was awarded his MD, and in 1971 he was elected a Foundation Fellow of the Royal College of Psychiatrists.

He was called up into the RAF in 1939, having been a member of the Volunteer Reserve for two years and was mentioned in dispatches in 1942 for his work as a Station Medical Officer on a bomber base. Later he served as a Neuropsychiatric Specialist at home and overseas. He was demobilized in 1945 and in 1946 made Deputy Medical Superintendent of St John's Hospital, Lincoln, becoming Medical Superintendent in 1947.

Alan Falla was Medical Superintendent during a period of great change in psychiatric hospitals, change which he welcomed and furthered. He unlocked the gates and doors of St John's Hospital, opening it to the community. He pursued modern methods of treatment, established out-patient clinics in the larger towns of North Lincolnshire, introduced hospital-based social workers and day care facilities. An Industrial Therapy Unit was set up with an important offshoot at Scunthorpe, where many patients were employed in the steelworks. A Mother and Baby Unit was provided for mothers with puerperal illness and for those having serious difficulties in handling their children. He always encouraged public interest in the welfare of psychiatric patients and their rehabilitation, and was active in setting up local branches of MIND. After his retirement in 1973, he worked part-time in the Prison service and continued as a member of the parole board.

Amongst his other interests were astronomy and motor cars: he founded Lincoln Astronomical Society, of which he was Vice President; he was President of Lincolnshire Automobile Club. He was an active member of the Church of England, a church warden and lay reader.

Alan Falla is remembered by his colleagues as a good and kind friend and entertaining companion, as well as an accomplished physician, and is much missed. He is survived by his wife, Margery, two sons and a daughter.

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Wilhelm Guenther Paul Kraemer, Consultant, 79 Harley Street, London W1.

Dr Wilhelm Kraemer, a Foundation Fellow of the College, died in London on 30 December 1982 at the age of 71.

Kraemer was a prime example of that band of intellectuals who, driven from Germany by Nazi persecution, found their way to these shores bringing with them little more than their incomparable talents.

Kraemer qualified in medicine in Sienna, but he was early on attracted to analytical psychology and its relation to psychiatry, and to this end he underwent a Jungian Analytic Training. In the UK, he first established himself in Edin-