FROM 'CHILD GUIDANCE' TO 'CHILD AND FAMILY PSYCHIATRY':

Problems of Interdisciplinary Communication

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In March 1974 the DES and DHSS published a Joint Circular giving advice to local authorities on the provision and organization of Child Guidance (1). It recommended the establishment of interdisciplinary working parties whose brief would be to report to their Joint Consultative Committees (the function of which was defined by the DHSS in 1974) and hence, by December 1976, to the Ministries.

In Bedfordshire, a working party had already been set up in 1973 to propose plans for the future. This group contained administrators from the Health, Education and Social Service Departments, together with professional representatives from the 'Child Guidance' Service. After reorganization in April 1974 the group increased in number and its members were faced with changes in their job boundaries and terms of employment. In that year the clinic teams representing psychiatry, psychotherapy and social work also decided to change their name to the Child and Family Psychiatric Service because they felt that this was a more appropriate description of one part of the Child Guidance Service.

By this time the psychologists were moving away from the clinic teams to fulfil an organizational and administrative role within the Education Department, and their newly appointed administrator, although not qualified in psychology, appeared to have the support of his Department in seeking control of the redefined Education Psychological Service. The social workers had become part of a hierarchical organization and were responsible to the Director of Social Services; yet they had a continuing place as members of clinical teams within Health Centre settings.

From these insecure professional bases the group members attempted to deal with the task set them by the Joint Circular. This circular argued the case for extending help to more children with difficulties, and in this argument there was an implied criticism of ealier methods of working labelled 'Child Guidance'. Paragraph 16 stated: 'rather than a self-contained, highly specialized child guidance service which has operated in some areas, the concept of child guidance that now appears appropriate is of a network of services, each providing help for children with difficulties and their families, which collaborate in such different combinations as may be required to handle individual or general problems. Such arrangements will clearly need to be flexible; but this makes it the more important that they should also be well defined and understood.'

The working party saw that the phrase 'Child Guidance' was used as a generic term to cover a wide range of children's services. The clinic teams, who had carried the same name, and who had just changed their name to 'Child and Family Psychiatric Service' were confirmed in this decision, since it was clear that a small team of practitioners could not have the authority to plan a network of services as described in the circular.

We saw that the working party now contained three separate but overlapping components which in part represented the wider network of services for children.

1. Community physicians and administrators representing the Departments of Health, Education and Social Services. The community physicians were answerable to the Area Medical Officer, and the other administrators respectively to the Chief Education Officer and the Director of Social Services. These three heads of departments were members of the recently established Joint Consultative Committee, and other administrator members of the group were included amongst its officers.
2. Practitioners from three disciplines represented the recently formed Child and Family Psychiatric Service. Of these, only the psychiatrists had 'clinical autonomy', that ill-defined but very real advantage of consultant status which freed them to work out their clinical priorities (although child psychotherapists were supported by their professional body in working towards comparable ends). The non-medical administrators resisted this concept which they found difficult to relate to the hierarchical systems in which they worked. The social workers had scarcely begun to work out their professional role *vis-à-vis* their employing authority and had no clearly defined terms of employment.
3. The educational psychologists and their administrator formed a distinct sub-group, representing the re-defined Education Psychological Service. The Education Department presented a view of

this service as complementing and perhaps overlapping with the Child and Family Psychiatric Service; but as having many other commitments and limited personnel. What became obvious was that these increased commitments had created a situation in which continuing joint work between the two agencies was seen as a luxury rather than a necessity.

By March 1976 the group was trying to put together contributions from the three Departments and was having little success. Discussions were becoming increasingly rancorous and unproductive. It was therefore decided to write the first draft of a paper which would try to represent the combined views of the working party, and the practitioners agreed to attempt this task.

The paper which resulted included a section on the future role of the educational psychologists within the Child and Family Psychiatric Service and was unacceptable to the Education Department, which felt responsible for producing its own separate document. The Child and Family Psychiatric practitioners then realized that all they could do was to write a paper which spoke for themselves. This understanding was of great importance, for not only did it enable the study group to move forward again but it also made the practitioners again realize that they could only make one contribution to a total service for children.

At the final meeting of the group the practitioners modified their paper on the advice of the administrative members in the expectation that this would make it possible for the paper to go forward to the Joint Consultative Committee in time for the deadline of December 1976 to be met. They also hoped that complementary papers, written by members of the Education and Social Services Departments, would be offered alongside their own. Their paper did not, however, reach the Joint Consultative Committee at that time; and their efforts to understand this made it clear that no administrative member of the group was able to speak for his seniors, even to the extent of arranging that the paper be submitted for criticism to a preliminary officers' meeting of the Joint Consultative Committee.

The practitioners now felt that the Joint Consultative Committee had a right to know about these inter- and intra-departmental difficulties, and requested that their paper in its own right should be drawn to the attention of the officers of the Joint Consultative Committee, and that it should be accompanied, as already suggested, by clarifying reports written by administrators and acceptable to their Departments. They hoped that in this way inter-departmental difficulties outside the scope of the working party could be resolved within the Joint Consultative Committee rather than be masked from the very body whose duty it was to report direct to the Ministries on the future of clinical services.

Although the deadline of December 1976 was not met, this request was carried out, and in March 1977 the report of its officers was submitted to the Joint Consultative Committee plus memoranda from the Chief Education Officer, the Director of Social Services and also the Practitioners' Working Paper. The practitioners have since been told by the chairman of the working party that the Joint Consultative Committee 'accepted' these documents.

Comment

There have been recent attempts (2, 3, 4) to clarify the role of a psychiatric consultant working in a team which includes other professionals employed by hierarchical systems, such as Departments of Education and Social Services. Such clarification is essential for child psychiatrists who, as members of interdisciplinary teams, have a responsibility to a wider network of families and other professionals, also employed by hierarchies, within their catchment areas.

This paper illustrates the conflict between administrators, who operate within hierarchies, and a partially autonomous service of which some members are also answerable to hierarchical systems rather than being free agents. The internal difficulties of the working party precisely reflected those of the precariously formed teams working within the psychiatric service. It is clear that a reconstituted group will need to meet regularly in order to continue the joint planning of a clinical service in child psychiatry, and the practitioners see it as essential that each member of this new group who is part of a hierarchical system should be clear about the limits of his delegated responsibility. Otherwise the very concept of clinical teamwork becomes invalid.

It will also be necessary to build links with the Joint Consultative Committee, of which we know very little. Our service has had no written communication with the committee; nor, despite our contact with individual members, have we seen a membership list. We do not know how many of its members are elected and how many co-opted, nor whether there may be changes relating to local council elections. The relationship between this body and the area-based joint care planning teams also remains unclear, as are its links with central Government.

Finally, in order to avoid the continued use of the devalued term 'Child Guidance', the working party will need to explore alternative concepts, such as a Joint Liaison Child Service which could link together

the local agencies working with children and families. We hope, by these means, to make better use of limited resources and to formulate clearer policies about the effective practice of child psychiatry.

References

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(4) Royal College of Psychiatrists (1977) The Responsibilities of Consultants in Psychiatry within the National Health Service. *Bulletin*, Sept. 1977, pp 4–7.

CORRESPONDENCE

MYTHS AND 'MIND'

DEAR SIR,

Mr Smyth disregards my thesis, attacking both me and my accuracy. The two main points made by me (*Bulletin*, March, p 41) and totally ignored by Mr Smyth (*Bulletin*, June, p 118) were that, firstly, groups such as 'MIND', by their support of, in my view, false panaceas, arm Governments and Administrations with the political weapon of 'resources spreading' that is, giving everyone involved a little to keep them quiet and no one enough to do any real good.

The second point is that the major expertise in Mental Health is housed in the psychiatric hospital, and therefore this institution and staff should be central in all activities involved in Mental Health.

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PROVIDING FOR SPECIAL INTERESTS IN A DISTRICT PSYCHIATRIC SERVICE

DEAR SIR,

As one who was a member of the Sub-Committee which published the Tunbridge Report (1), I write to endorse strongly the letter from Dr Ekdawi (*Bulletin*, March 1978, page 47). On the basis of the Report I organized a purpose-built rehabilitation complex in our psychiatric unit in this Group of general hospitals which approximates as far as possible to the recommendations included in that Report. A designated Consultant in Psychiatric Rehabilitation was appointed, and the rehabilitation complex comprises three sections—an industrial therapy unit, a day hospital and an occupational therapy department. Each section accommodates approximately 60 patients. In my view the whole complex has contributed enormously to the ability o. a general-hospital-centred psychiatric service (2 and 3) to cope with the total case-load involved. I would therefore add to the plea that the College should include Rehabilitation as a special interest for appropriate future consultants.

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References

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