Mental Health Act, with a consequent increase in the number of patients formally detained.

As stated in our Introduction, while not accepting all the arguments, the College considers that the COHSE Report has made a valuable contribution to the debate which will continue until all the different views have been crystallized and either ratified or rejected by Parliament.

The College is concerned that much of what is intended as guidance in the Report will be regarded by many as a statement of the considered policy of COHSE.

THE ROLE, RESPONSIBILITIES AND WORK OF THE CHILD AND ADOLESCENT PSYCHIATRIST*

Introduction

This document, produced by the Child and Adolescent Psychiatry Section of the College, is aimed at administrators, trainees considering entering the specialty, and colleagues in other disciplines. Its purpose is to describe the role of child and adolescent psychiatrists today, who work largely as part of a multidisciplinary team and may be based in a hospital or in the community. There is increasing emphasis on community work: assessment, treatment and preventive work is carried out with children and their families in close liaison with mainly non-medical colleagues. Such multidisciplinary teamwork has many advantages, but presents delicate problems in ethics and organization. In what follows 'child psychiatrist' will be generally 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. It is best for experience in neurology and paediatrics to precede general psychiatric training, which is a three-year preparation for the examination for the Membership of the Royal College of Psychiatrists (M.R.C.Psych.). General psychiatric training provides experience in diagnosis and managment of adult psychiatric patients in different settings and using a variety of therapeutic skills. At this stage, the trainee is introduced to the specialties, including child psychiatry, and some may have a personal psychoanalysis. Specialist training in child psychiatry starts at senior registrar level. Training is both academic and clinical. The trainee's work, supervised by a consultant child psychiatrist, develops so that by the end of training he should be capable of leading a multidisciplinary child psychiatric team and organizing a clinical service.

Appointment to the post of consultant child psychiatrist in the National Health Service is by open competition by an Appointments Committee, including others in the same field and representatives from Universities and Health Authorities. An assessor from the Royal College of Psychiatrists advises on the standard of training of the applicants. A guideline for approval for training programmes in child and adolescent psychiatry has been issued by the Joint Committee on Higher Psychiatric Training (1).

2. The Responsibilities of a Consultant Child and/or Adolescent Psychiatrist

(i) *General*

A consultant child psychiatrist in the NHS has clinical autonomy, as do consultants in other fields, with consequent legal, professional and moral obligations. The consultant is usually based in an NHS hospital and/or a Child Guidance Clinic run by a Local Education Department or Area Health Authority. Many child psychiatrists spend much of their time in a wide variety of settings where disturbed children and adolescents are to be found. Collaboration and consultation occurs with many other professions as well as other branches of medicine. Since the work necessitates much closer involvement in a multidisciplinary team than is the case in other branches of medicine, problems concerning clinical responsibility have arisen and are discussed in Section 5.

(ii) *Clinical Responsibilities*

The clinical services include:

(a) diagnostic assessment;

(b) treatment of children and families;

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(c) consultation to primary care-givers in the community, with general practitioners, paediatricians, social workers, teachers and house parents, which may or may not involve an assessment of a particular child and may have a more general teaching role;
(d) legal reports, as to Juvenile Courts;
(e) in-patient services requiring 24-hour consultant cover.

(iii) *Prevention of emotional and behavioural disturbance and the promotion of emotional well-being*

Child psychiatrists should be involved in the prevention of avoidable mental and emotional distress by advising staff in neonatal and paediatric wards, children's homes, nurseries, schools, etc., as well as parents and foster parents.

(iv) *Administrative Responsibilities*

The consultant should ensure that families referred to the clinic or unit are seen, diagnosed and treated with appropriate and efficient use of available techniques. He should facilitate good comunication within the service and within the community, and continue development of the service by active encouragement of discussion and study for the monitoring of current services and evaluation of new methods. Administration must include maintenance of confidentiality. Attendance or representation at appropriate committees of authorities (as AHA, LA or JLC) is essential to the organization, support and monitoring of working conditions of staff so as to enable them to work to their best capacity.

(v) *Teaching Responsibilities*

These include: the training of junior staff in child psychiatry, participation in the training of other medical specialties, especially adult psychiatry, paediatrics, general practice and community medicine; of nurses and of others concerned with the care of children. Wherever possible there should be close contact with appropriate university departments.

(vi) *Advancement of knowledge in the specialty*

As in any specialty, it is essential to keep abreast of and contribute to the literature in the field.

(vii) *Development of the Profession of Child and Adolescent Psychiatry and of Medicine*

A responsibility requiring active involvement with the Royal College of Psychiatrists, the British Medical Association or local scientific and professional bodies.

(viii) *Liaison and Public Relations*

This responsibility is shared with other members of the team, but the psychiatrist particularly must maintain contact with other doctors in the community.

3. How should a Child or Adolescent Psychiatrist apportion his time?

When a child psychiatist's time is being organized, the following considerations should be noted:

1. The *incidence* of psychiatric disorder varies between 7 and 20 per cent, but only 1–2 per cent of children are referred to child guidance or psychiatric clinics.
2. There is also wide variation in the *distribution* of child psychiatric and other resources. An acceptable level is suggested in Section 4.
3. The pattern of child psychiatric practice varies from clinics offering individual treatment to a few cases to an increasing proportion of clinics offering a wide range of techniques to help more children and families.
4. The time taken for diagnostic and therapeutic work is longer than in many other medical specialties.
5. Demands from many agencies have to be met (Section 2.2 and 2.3). It is suggested that a consultant might spend one-third to one half of his time in direct contact with children and families, a further third in consultation with primary care-givers and the rest in the other activities mentioned in Section 2.

4. Minimum Facilities required to fulfil Responsibilities

(i) *Staff for Child and Adolescent Psychiatric Service*

(a) *Psychiatrists*

The College has recommended a short-term aim of one consultant psychiatrist per 150,000 of total population with an ultimate aim of 1 : 100,000; a similar level to that expressed by the Court Committee (2) expressed as 1 : 35,000 child population. More child psychiatrists will be required in areas of special need, such as inner city areas. Trainees should be considered as additional to population requirements, since not all their time should be devoted to service; indeed they will use some of the consultant's time in their training. Further increases in staffing level will be needed to provide services for adolescents.

(b) *Non-Medical Professional Staff*

The Underwood Committee recommended, in addition to the psychiatrists, educational psychologists and psychiatric social workers,

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in a ratio of 1 : 2 : 3. To this team a child psychotherapist may be added. In practice the psychologist may be clinical or educational. Educational psychologists should be employed in both the child psychiatric team and the School Psychological Service. Members of the team should be appointed and work together for long enough periods to develop adequate experience in the field (3).

(c) *Secretarial Staff*

The clinic secretary is an important adjunct to the team, dealing with case notes, all communications and practical arrangements. Other agencies requiring consultation should provide appropriate secretarial support.

(ii) *Non-Medical Staff in other Community settings*

Social work and psychologist support is as important to the psychiatrist working elsewhere in the community as it is in the clinic.

(iii) *Physical Needs*

Clinics need to be easily accessible and to contain sufficient well sound-proofed rooms for interviews, playrooms and offices. When furnishing, the emphasis should be on a relaxed, welcoming atmosphere. Waiting rooms, locked cabinets for notes and dictating facilities are essential; audio and/or video recording facilities and one-way screens are optional but often found useful. Play material is an essential diagnostic and therapeutic tool requiring constant replenishment.

(iv) *Access to other Medical Facilities*

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 beds under their care. This may be done in a paediatric ward, but a special in-patient or day-patient unit may be required. It is debatable whether all child psychiatrists need have direct access to such units. The Court Committee recommended 20 short-stay beds per 250,000 children (pre-adolescent) and (minimal) 20–30 day places for 60,000 children. The College has in addition recommended a three-fold increase in adolescent places (4).

(v) *Access to other Facilities*

Equally important is access to a full range of psychological, educational (library) and social facilities.

5. The Child Psychiatric Team. Problems of Organizational Relationships

Child psychiatry is the same wherever it is practised. We therefore endorse the Court Committee's recommendation (para. 15.44) (2) 'that the distinction between Child Guidance Clinics and Psychiatric Hospital Services should be dropped. Both are and should be recognized 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'. The situation may be different in Scotland.

Child psychiatric services involve collaboration between different disciplines and the core child psychiatric team consists of child psychiatrists, (psychiatric) social workers, educational and/or clinical psychologists and, in some areas, child psychotherapists. In some settings, psychiatric nurses, remedial teachers and occupational therapists may also be involved. It is essential that the same individuals should 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.

Child psychiatrists have always attached high importance to a multidisciplinary team approach, and it can be said that where we have led others are now following. A recent publication by the College (5) discusses the question of the multidisciplinary team as it relates to adult psychiatry. But although we have always placed emphasis on team work, such an approach is not an easy one. In many child psychiatric teams rivalries and power struggles have always gone on, but the concept of the psychiatrist as medical director and therefore arbiter of final clinical decisions has meant that such team interaction has often remained hidden and not properly worked out nor understood.

With the emergence, however, of stronger professional identities for the other members of the core team—psychologists, social workers and child psychotherapists—these issues have become more open. At this time it is impossible to make a definitive statement about the precise responsibilities of each core team member, and this section of our document must therefore be read only as a presentation of some of the issues currently being discussed, and not as a blueprint or final 'solution' to these complex matters.

Until recently the nature of the organizational relationships between team members has not been openly examined and has rarely been made explicit in contracts or job descriptions. Recently, however, an attempt has been made to examine these relationships. This work arose out of projects undertaken in

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child guidance and allied settings over the last few years by the Brunel Institute of Organisational and Social Studies, and from discussions at a number of conferences held by them in the past two years on the organization of child guidance, attended by a wide variety of practitioners and administrators from the field. These discussions confirmed that there was considerable confusion and uncertainty about professional relationships within teams, including the distinctive role of the various professionals involved, particularly regarding authority relationships between them, with uncertainty about the special role of doctors and the concept of medical responsibility (6).

6. Autonomy and Hierarchy

One important difference between the doctor and other team members, regardless of their professional qualifications or experience, is that the consultant psychiatrist is in autonomous practice. This means that he has complete autonomy to pursue his professional practice as he thinks best provided he stays within certain broad limits of professional ethics, etc., and he cannot clinically be subjected to managerial relationships (Sec. 2(i)).

This is not at present the case either for social workers or for educational psychologists. (The position of child psychotherapists is less clear.) Social workers and educational psychologists are employed by Departments whose structure is hierarchical, and both professions are therefore in *agency service*. This is a situation in which the professional practitioner is employed to act as the *agent* of the employing authority, and he may therefore be subject to a managerial relationship.

This important difference needs to be clarified at national level, because it is clear that at present it is only the special position of the consultant psychiatrist carrying overall responsibility which makes it possible for child and family psychiatric units to function independently of both Education and Social Service Departments and for medical confidentiality to be respected. This is the same argument which is discussed in the College publication already referred to, which states: 'True multidisciplinary team work at clinical levels can be recommended as probably the most efficient way of staff co-operation in the treatment of patients only provided that each member of the team is given full powers to make decisions.' This implies that hierarchial disciplines should decentralize their powers to their members of the teams of the same order as that of the medical profession (5).

7. Confidentiality

The public have special expectations of a doctor, especially with respect to issues of confidentiality which have been discussed recently by the College (8). Most child psychiatrists are unhappy about their responsibility for ensuring confidentiality unless they can control clinic policy. The General Medical Council reiterates BMA guidance on the doctor's duty in matters of confidentiality: 'It is the doctor's duty strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information which he has learned directly or indirectly in his professional relationship with the patient.' Exceptions are made when the patient or his legal adviser gives valid consent, or the information is required by law. 'If, in the doctor's opinion, disclosure of confidential information to a third party is in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be so given. If the patient refuses, then only very exceptionally will the doctor feel entitled to overrule that refusal.' 'A doctor should be prepared to justify his action in disclosing confidential information' (7).

Disciplinary action, with the ultimate sanction of being removed from the Medical Register may follow breaches of medical ethics, and in this area, too, there are differences from the other professionals with whom the doctor works.

8. The Organization of the Clinical Team

Whilst in hospital services the consultant is clearly seen as the clinical leader of the team, this is less clear in child guidance centres. Many child psychiatrists feel that they cannot exercise their medical responsibility unless they have full control of the setting where they work, whilst others find this less of a problem. Whatever is decided needs to be with the consultant's agreement, bearing in mind the issue of confidentiality and the tasks referred to in the section on responsibilities of the consultant (Section 2).

Models of organization of services for children with social and educational problems, and their families already exist in social-services-centred and education-centred services. In these, social workers and psychologists respectively exercise primacy.* In considering other possible models for the future organization of services for disturbed children and their families, the Brunel working paper 'Future Organisation in Child Guidance and Allied Work' (6) describes two other models (i) Health-centred services, i.e. 'psychiatric' or 'mental health' services in either hospitals or clinics, and (ii) distinct 'child guidance' services, concerned with health, social and education problems in equal measure.

In (i), child psychiatric services, *the psychiatrist would have primacy*. All referrals would be to him and

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he would take *prime responsibility*.† He would delegate or refer to other team members, but would retain responsibility for monitoring and co-ordinating the work of the other team members. With his junior medical staff he would have in addition a managerial role.

In the Brunel working paper conception of a 'distinct child guidance' service in (ii), neither the psychiatrist nor any other professional would carry primacy. The general idea would be that of referral of each case to the team as a whole. The final allocation or prime responsibility for each case would thus be seen as having to be negotiated case by case (and this is recognized as an obvious difficulty). No one professional would stand as an obvious Director. No one agency would stand as carrying obvious responsibility for funding and development. The logic would seem to point ultimately to the need for separate 'Child Guidance Authorities' on some scale.

In our view neither model deals adequately with the issues of hierarchy and confidentiality referred to above, but *we find the first model preferable where the consultant psychiatrist has prime responsibility, both because it is more economic, and because accountability is more clearly defined.* We feel that these issues need discussion at national level.

* *Primacy*. Where a number of practitioners from different disciplines or professions work together in any given setting, one (or more) of these disciplines or professions has primacy in the setting concerned if prime responsibility for all new cases automatically rests with one of their number, whatever further referrals they make thereafter. Primacy is always relative to a particular field of work (and perhaps even to a particular setting).

† *Prime Responsibility* in any case implies the right and duty of the person who carries it: (a) to make a personal assessment of the general needs of the case at the time of assumption of prime responsibility; (b) to undertake personally any action needed in consequence or to initiate such action, through subordinate or ancillary staff; (c) to refer as necessary to colleagues and other independent agencies for collaboration in further assessment or action, or for action in parallel; (d) to keep continuous awareness of the progress of the case, and to take further initiative as necessary; (e) to decide when to relinquish extended collaboration with colleagues, or when to terminate all further action on the case (This perhaps applies only when the person concerned is in autonomous practice.)

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DEPENDENCE/ADDICTION GROUP

Following an invitation in the January issue of the *Bulletin*, a meeting was held at which it was decided to set up a Group dealing with Dependence/Addiction. The terms of reference of the Group are: (1) to promote communications and knowledge about dependence on alcohol, tobacco, other drugs, and similar related behaviours; (2) to promote training and the provision of services in this field; (3) to act as a source of information within the College to help develop planning and further policies; (4) to provide members for committees and working parties when appropriate. The Chairman is Dr Brian Hore, of the Withington Hospital, Manchester, and the Honorary Secretary is Dr Robin Murray, of Bethlem Royal Hospital.

The first Scientific Meeting of the Group will be held at the Royal Society of Medicine on Thursday, 6 July, at 4 p.m., in conjunction with the College's Annual Meeting. Topics to be covered include Detoxification of the Chronic Drunken Offender; Current Methods of Treatment of Opiate Addicts; and The Anatomy of Alcoholics Anonymous. Professor H. J. Walton will be in the Chair, and the speakers will be Dr Brian Hore, Dr M. Mitcheson and Dr D. Robinson. The final programme will be circulated with the programme of the College Annual Meeting.

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