
TYPES OF PSYCHIATRIC TREATMENT

Psychiatric treatment for children—the organisation of services

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This is the sixth of a series of articles on treatment of child psychiatric disorders.

The Court report in 1976 laid down the classic blueprint for the organisation of children's mental health services.¹ Since then the priorities of health and other services have changed.² Social services in some parts of the country have had to redirect social workers from child guidance to child protection work, often because of the major increase in reporting of child sexual abuse, and now also have to consider the implications of the Children Act.³ Education services have had two major education acts to deal with,^{4,5} and they are subject to the turbulence of further continued reform.

This paper looks at dynamics more than structures and offers observations on how modern approaches, especially of health economics, are shaping an inner London child psychiatry service in the new context of the NHS reforms.⁶

(A) Methodologies to improve services

1. MARGINAL COST-BENEFIT ANALYSIS

Marginal analysis in health economics is a method of evaluation when planning a service programme to find the most cost-beneficial way of proceeding.⁷ The approach of marginal analysis:

(a) Acknowledges the limitations of resources. The child psychiatry service probably has a fixed budget, and opportunities for increased funding look limited.

(b) Proceeds from current available resource provision and use. The first step in planning is not therefore to survey the hypothetical 'child psychiatric needs' of the whole population and from this recommend 'ideal provision', but to look at current provision, its uptake, and effectiveness.

(c) Tries to establish priorities for a given type of provision, rather than to set an arbitrary standard. It seems difficult in the usual multi-disciplinary child psychiatry setting for instance, to answer the question 'Which cases would not benefit from long term child psychotherapy?'. On the other hand, a 'marginal' type of question—'What sort of cases have in the last year benefited least from long term individual psychotherapy?' has been found to be more readily answerable, and provides an opportunity for the future more effective direction of resources.

(d) Tries to identify the range of costs, both for the service and its users. These could include for the child and his or her family

attending child psychiatry outpatient appointments for example distress, stigmatisation, loss of education and income, and disruption of household arrangements. For the child psychiatry service costs could include not only the resources devoted to the treatment, but also the stressfulness of the case, and the opportunity cost of not offering the resource to another, more responsive, case.

(e) Tries to identify the range of benefits, for instance, acceptability, availability, efficacy of treatment, accessibility, and equitability. In child psychiatry the child whose symptoms are relieved is not the only beneficiary; there are gains for the parents and siblings, and often also the school. 'Benefits' for the service could include contributing to the fulfilment of the service contract, the opportunity for learning and research, and variety.

(f) Concentrates on marginal rather than average costs and benefits. So far, costings in child psychiatry are very rudimentary, due to the non-standard nature of problems, situations, and interventions. However, it is clear that it would be cheaper (and easier) for an established programme—say of group work for sexually abused children—to take on a few extra cases, than it would be to provide a new, similar programme for a small number of children not far away. This is even more obvious for expensive provision such as adolescent inpatient admissions.

(g) Establishes a framework in which judgments of relative benefit are made explicit and thus trade offs are clearer. Although formal quantification of costs and benefits is limited and difficult in child psychiatry, informally extreme categorisations of the cost:benefit ratios of cases have been found acceptable and are the subject of further study. For instance, most clinicians, when asked, could respond to the question 'Which of your recent cases represented the poorest clinical gain in relation to the resources put in?' Then, if such cases have common characteristics, there is the possibility of considering limiting input at an earlier stage, in order to devote resources elsewhere.

2. AUDIT

For child psychiatry, audit offers a way of improving treatments and services using local data and nationally available information educationally, even when the resources and opportunities for mounting double blind controlled trials are not available.

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In our district, multidisciplinary audit in child psychiatry is being used explicitly to improve the service offered at a number of levels as recommended by the Royal College of Psychiatrists.⁸

(a) *Team level*

i. *Quality of case notes*—extremely simple standards have been found to be robust but revealing:

- Can the file be found?
- Is the cover/front sheet information complete?
- Are the notes filed correctly?
- Is there a typed first assessment?
- Have the general practitioner (GP) and referrer been informed of the outcome of assessment?
- Is there a note of action in the last six months, or a letter to GP and referrer advising of closure?

After 15 months, standards have considerably improved.

ii. *Commissioners' requirements*—This year the commissioners asked for the following to be audited:

- Following a GP referral, in 80% of cases a meaningful reply should be sent to the patients/clients within two weeks,
- Time for response to GP after first assessment to be reported,
- Waiting time for appointment.

Auditing these has also led to an improvement in standards, although more administrative support and appropriate computerised information systems are necessary for full implementation.

(b) *Interteam level*

The four consultant teams of the district hold audit meetings each term with an educational focus on topics of major treatment relevance, to consider current practice and 'best practice' advice, and how to modify management in the light of this. 'Soiling' and 'hyperactivity/conduct disorder' have been considered so far.

(c) *Planning group level*

At the district planning group level service relevant audit is coordinated by means of:

- General information review,
- Promotion of specific audit projects,
- Organisation of other quality oriented projects such as patient satisfaction surveys, etc,
- Resource issues review,
- Coordination of other audit results for annual review and report to commissioners,
- Liaison with other audit committees within the hospital and at regional level.

3. OUTCOME MEASURES

Outcome studies of treatment in child psychiatry are being more frequently performed now, and are encouraging,⁹⁻¹¹ but outcome measures suitable for general use are not yet available.

This is not surprising given the variety of contributory factors to childhood mental disorder, the degree of comorbidity, and the eclecticism of interventions. As databases become more widespread, however, it is worthwhile beginning with what seems feasible locally.

(a) *Administrative outcomes*

Administrative outcomes are the simplest to determine, and are worth monitoring—for example:

- Referral not accepted,
- Referral withdrawn,
- Case attended,
- Case never attended.

Referrals have been monitored on this basis at local clinics for a number of years, so comparisons and trends are apparent. Other clinics have found useful slightly more complicated categorisations, adding in mode of discharge.^{12 13}

(b) *Therapeutic outcome measures*

Systematic attempts to measure therapeutic outcome are now being evaluated.⁹ What should be done with outcome measure results? At present, differences between different centres for apparently the same condition would be very difficult to evaluate, but within the same centre outcomes should be an aid to decision making. Repeated measures of progress on individual cases would also be a guide to when intervention could be terminated.

In the future, quality adjusted life year (QALY) type measures may be evaluated,¹⁴ to answer not only 'within-programme' but 'between-programme' questions, such as—what are the comparative costs and therapeutic gains of an average child psychiatry and an average paediatric course of treatment?

(c) *Performance indicators*

The national requirements of the Körner report are ill suited to child psychiatry,¹⁵ but are still collected through most hospitals' patient administration systems. A survey conducted by the author of all consultant child psychiatrists in the region revealed that each Körner information requirement was interpreted variously. As a result of attempts to increase local validity (meaningfulness), central reliability was completely lost. However, as Jenkins has rightly pointed out, process measures should not be used as a proxy for outcome measures.¹⁶

(d) *Health outcomes*

The monitoring of childhood 'health states' such as the parasuicide and suicide rates, the incidence of psychiatric disturbance, and the emotional impact of psychosocial disadvantage, has been recommended as an appropriate method of measuring outcome for child psychiatry.¹⁶ This appears bizarre to the clinician—rather like judging the performance of the accident and emergency consultant by the number of road accidents, and shows how important it is to have agreed objectives for a service before

setting out to measure its effectiveness. However, population morbidity measures (such as the child abuse rate) could certainly help to indicate priorities for intervention.

4. CONSUMER RESEARCH AND QUALITY

'Consumerist' approaches are now important in evaluating, and therefore determining, services. Who is the consumer in child psychiatry?

(a) *The child and the family*

i. Preparatory information—A local survey¹⁷ supported other findings^{18 19} that parental understanding of child psychiatry services is limited. As outcomes may be better if expectations of family and clinic are congruent,²⁰ we have reviewed information sent out at the different clinics and are in the process of improving it.

ii. Improving attendance rate—Non-attendance at appointments is commonly noted in child psychiatry,¹³ and can be a considerable waste of professional time. Following the suggestion to telephone some families beforehand has helped reduce the non-attendance rate in one of the local teams.^{21 22} Requiring questionnaire completion was thought to be too demanding for our population,^{22 23} as even routine confirmation of appointment is only erratically complied with.

iii. Waiting time—A local survey showed that parents who thought the wait for appointment was 'too long' had waited an average of 8.6 weeks; parents who thought the wait was 'OK' had waited a mean of 7.1 weeks.¹⁷ Efforts are made to keep the waiting time down to six weeks if possible. If, as has sometimes happened due to staff cuts, a waiting list of three months develops at a clinic referrers are advised about alternatives.

Although a longer waiting time for an appointment has been noted to reduce likelihood of attendance,²⁴ audit of one local team's attendance rate showed a surprising tendency for offer of a rapid appointment (within 1–3 weeks) to be associated with a higher failure rate, so that time taken over checking willingness to attend was concluded to be more important.

iv. Patient satisfaction: process—Satisfaction with such 'process' variables—such as ease of finding the department, the pleasantness of the waiting area, the acceptability of the toys and reading material—is currently being surveyed in our hospital department. It is hoped that this will reveal opportunities for improvement, and also possibly provide ways of comparing different sites in a standardised way, and where necessary underpin arguments for upgrading of facilities.

v. Patient satisfaction: outcome—Successful attempts to measure parents' views of outcome have been reported.^{9 25} As satisfaction is likely

to be increased if treatment goals with parents and or children are agreed a goal attainment rating scale is being tried locally as a first step in this direction, and we are considering making it more 'computer game-like' to interest the children.

vi. Acceptability—The local child population is very mixed culturally, with the largest minority ethnic group being Afro-Caribbean. We have aimed, in the last few years, to make the service more acceptable to ethnic minority families, and have undertaken appropriate staff education, appointed more ethnic minority staff members, and offered training specifically to ethnic minority students. Finding appropriate toys is not easy, but is visibly appreciated. There is no longer a marked difference in uptake between the hospital and community provision.

(b) *Other health professionals*

GPs, hospital and community paediatricians, health visitors, and school nurses can also be customers of child and family psychiatry services. Dissatisfaction can easily arise if there are situations of high risk and/or distress, and the child psychiatry service seems slow or remote. This can occur not merely through the limitation of resources, but because 'child guidance' had until recently little relationship with the primary health care system. Improving communication must therefore be a priority, as GPs themselves are making clear.²⁶

i. Information—Referrers' knowledge and expectations of the services of one of the local child guidance units were found to be more accurate than the parents', but still somewhat vague.¹⁷ Leaflets describing clinic services were in popular demand previously, and need updating. There is an active department of general practice, through which other information is disseminated, and occasional 'Meet the GP' sessions are arranged.

ii. Letters—Even though many referrals to children's mental health services are not from GPs, there is usually a policy that the GP should be kept informed. Audit of our own practice in this respect showed a frequent deficiency but is now improving.

iii. Liaison—Over the last few years we have increased outreach to GPs²⁷ and liaison with hospital and community paediatric services including health visitors. The impact of these efforts is difficult to quantify, but they are all subject to review and are dropped if not successful or if other provision becomes available, such as the appointment of a specialist counsellor. Requests for further involvement or for training are encouraging.

iv. Satisfaction—Locally, surveys of GP satisfaction have so far been carried out at hospital and general psychiatric service level only, but elsewhere surveys of the satisfaction of GPs and health visitors with their local child and family psychiatric service with informative results have

been reported.^{28 29} Such surveys are now being requested by commissioning authorities, and they offer an opportunity to identify deficiencies that may support requests for more resources.

(c) *Education and social services*

Locally, as with many 'child guidance' services, referral has been open to education and social services; clinics were planned, staffed, and administered with the local authorities. Satisfactory relationships with the local authority agencies are therefore crucial to the maintenance of the service, but may not be enough with local government budget pressures and competing statutory priorities.²

i. *Social services*—Our service offers regular liaison to area offices, arranges meetings at senior level to discuss priorities, offers training courses, and attends committees such as the Area Child Protection Committees and Joint Care Planning Groups. Nevertheless hospital social work has been subject to freezes and cuts, and unrealistic expectations easily arise with respect to the child psychiatry service's appropriate role in and capacity for child abuse work. (Involvement in child abuse can be a major part of a child mental health service's work, but is exceptionally consuming of resources.^{30 31}) 'Public relations' work is therefore constantly necessary.

ii. *Education*—Since the abolition of the Inner London Education Authority the funding for the non-health professionals in the two local child guidance units has been under repeated threat. However, while resources are being put in by education, it is important to work out priorities with them—an example is working to prevent expulsion from school, rather than spending a lot of time on special educational assessments after the event.³²

(B) The purchasing environment

1. COMPETITION OR COLLABORATION?

Improving efficiency is a clear aim of the NHS reforms, but the emphasis is more on costing throughput than clinical outcome, and the intended method is that of the market, which can produce distortions.^{33 34}

Although many small child psychiatry services are potentially monopoly providers, in a large city such as London purchasers might theoretically invite competitive tenders. As there is no obvious 'spare' capacity currently this would be wasteful of resources as cost differences between services are likely to be partly due to inaccurate allocation of costs, and differences of 'case-mix'. Encouraging collaboration between adjoining services would be a better strategy for ensuring the availability of a comprehensive but mainly community based services, with some possibility of consumer choice. Standardisation of information collection and quality ratings would be helpful and some specialisation at different centres might lead to greater efficiency at the margins.

2. DEMAND AND NEED

Basic epidemiological information is already available in child psychiatry, including knowledge of the social concomitants of childhood disturbance that are more readily measurable.³⁵⁻³⁷ 'Need' in child psychiatry is usually estimated to be much in excess of potential sources of help, but 'needs' are relative and are meaningless without a notion of possibilities of amelioration.^{7 38} 'Demand' can be very much altered by for instance publicising a service, and waiting lists can expand or contract according to the way they are managed. Purchasers should therefore be aware of the relativity of both demand and need.

3. OBJECTIVES, VALUES, AND PRIORITIES

The purchasers' responsibility is to procure the best possible value for money health services for their population. Accepting that resources are always limited, in child psychiatry some 'quality values' may have to be traded off against each other: accessibility versus initial consultant assessment, for instance, or comprehensiveness of case notes against information returns. Choices will have to be made over the use of time—for example, should a court request for assessment take priority over GP referred cases? Should there be more psychological support for terminally ill children and their families, or should there be a specialist team for autistic children? There must be discussion between purchasers and providers about objectives and values, which can lead to the establishment of agreed principles to determine priorities. Priorities should be considered in conjunction with those of the local paediatric and psychiatric services and of GPs. The local authority should also be consulted, to maintain and develop collaborative service arrangements.

In conclusion, the reorganisation of the NHS has produced many challenges but within it there are also opportunities for rethinking how to make the best use of child psychiatry services to reduce the burden of mental health problems for children now, and for their future adult lives.

1 Department of Health and Social Security. *Fit for the future: report of the Committee on Child Health Services*. Chairman: Professor SDM Court. London: HMSO, 1976. (Court report.)

2 Trowell J. What is happening to mental health services for children and young people. *Association for Child Psychology and Psychiatry Newsletter* 1991;14(5):12-5.

3 Department of Health. *The Children Act 1989*. London: HMSO, 1989.

4 Department of Education and Science. *The Education Act 1981*. London: HMSO, 1981.

5 Department of Education and Science. *The Education Reform Act 1988*. London: HMSO, 1988.

6 Department of Health. *Working for patients*. London: HMSO, 1989.

7 Mooney GH, Russell EM, Weir RD. *Choices for health care*. 2nd Ed. London: Macmillan Education, 1986.

8 Royal College of Psychiatrists. Preliminary report on medical audit. *Psychiatric Bulletin* 1989;13:577-80.

9 Pound A, Cottrell D. Audit and evaluation in child mental health services. In: Berger M. ed. *Clinic services: monitoring, evaluation and microcomputers*. Association for Child Psychology and Psychiatry. Occasional Papers No 1. London: ACPP 1989:10-4.

10 Rutter M. Psychological therapies: issues and prospects. *Psychol Med* 1982;12:723-40.

11 Weisz JR, Weiss B, Alicke MD, Klotz ML. Effectiveness of psychotherapy with children and adolescents: a meta-analysis for clinicians. *J Consult Clin Psychol* 1987;55:542-9.

- 12 Richards H. What do they do at the child guidance? *Association for Child Psychology and Psychiatry Newsletter* 1990; 12(3):13-7.
- 13 Cottrell D, Hill P, Walk D, Dearnly J, Ierouhou A. Factors influencing non-attendance at child psychiatry out-patient appointments. *Br J Psychiatry* 1988;152:201-4.
- 14 Walker SR, Rosser RM, eds. *Quality of life: assessment and application*. The Hague: MTP Press, 1988.
- 15 Nicol AR. Performance indicators in child and adolescent psychiatry. *Psychiatric Bulletin* 1989;13:94-7.
- 16 Jenkins R. Towards a system of outcome indicators for mental health care. *Br J Psychiatry* 1990;157:500-14.
- 17 Subotsky F, Berelowitz G. Consumer views at a community child guidance unit. *Association for Child Psychology and Psychiatry Newsletter* 1990;12(3):8-12.
- 18 Burck C. A study of families' expectations and experiences of a child guidance unit. *British Journal of Social Work* 1978; 8:145-58.
- 19 Garralda ME, Bailey D. Referral to child psychiatry: parent and doctor motives and expectations. *J Child Psychol Psychiatry* 1989;30:449-58.
- 20 Plunkett JW. Parents' treatment expectations and attrition from a child psychiatric service. *J Clin Psychol* 1984;40: 372-7.
- 21 Brockless J. The effects of telephone contact prompting on a subsequent attendance at a hospital department of child and adolescent psychiatry. *Association for Child Psychology and Psychiatry Newsletter* 1990;12(4):5-8.
- 22 Mathai J, Markantonakis A. Improving initial attendance to a child and family psychiatric clinic. *Psychiatric Bulletin* 1990;14:151-2.
- 23 Coyle TJ, Paramit KJ, Maisami M. Prospective study of intake procedures in a child psychiatry clinic. *J Clin Psychiatry* 1986;47:111-3.
- 24 Jaffa T, Griffin S. Does a shorter wait for a first appointment improve the attendance rate in child psychiatry? *Association for Child Psychology and Psychiatry Newsletter* 1990;12(2): 9-12.
- 25 Thomas H, Hardwick P. An audit of a small child psychiatry clinic. *Association for Child Psychology and Psychiatry Newsletter* 1989;11(1):10-4.
- 26 McGlade KJ, Bradley T, Murphy GJJ, Lundy GPP. Referrals to hospital general practitioners: a study of compliance and communication. *BMJ* 1988;297:1246-8.
- 27 Subotsky F, Brown RM. Working alongside the general practitioner: a child psychiatric clinic in the general practice setting. *Child Care, Health Dev* 1990;16:189-96.
- 28 Markantonakis A, Mathai J. An evaluation of general practitioners' knowledge and satisfaction of a local child and family psychiatric service. *Psychiatric Bulletin* 1990;14: 328-9.
- 29 Markantonakis A, Mathai J. An evaluation of health visitors' and social workers' level of knowledge and satisfaction of a local child and family psychiatric service. *Psychiatric Bulletin* 1991;15:140-1.
- 30 Oliver JE. Child protection by child and family guidance workers. *Psychiatric Bulletin* 1991;15:197-9.
- 31 Wressell SE, Kaplan CA, Kolvin I. Performance indicators and child sexual abuse. *Psychiatric Bulletin* 1989;13: 599-601.
- 32 Subotsky F. Assessment for special education in a child guidance unit. *Psychiatric Bulletin* 1990;14:16-18.
- 33 Light DW. Effectiveness and efficiency under competition: the Cochrane test. *BMJ* 1991;303:1253-4.
- 34 Quam L. Improving clinical effectiveness in the NHS: an alternative to the white paper. *BMJ* 1989;299:488-50.
- 35 Graham P. Epidemiological studies: In: Quay JC, Werry JS, eds. *Psychopathological disorders of childhood*. 2nd Ed. New York: Wiley, 1979:185-209.
- 36 Rutter M, Cox A, Rupling C, Berger M, Yule W. Attainment and adjustment in two geographical areas. *Br J Psychiatry* 1975;126:493-509.
- 37 Rutter M, Tizard J, Whitmore K, eds. *Education, health and behaviour*. London: Longman, 1970.
- 38 Stevens A, Gabbay J. Needs assessment needs assessment. . . *Health Trends* 1991;23(1):20-3.

Brittle bones and battered babies

The late Dr Leonard Taitz of Sheffield provided much in the way of clear thinking about the problems of child abuse. In a leading article in the *British Medical Journal* in 1987 he discussed the diagnosis of osteogenesis imperfecta in children with unexplained fractures.¹ Of the four types, type I (80% of all osteogenesis imperfecta) is almost always associated with blue sclerae. People with types II and III have multiple fractures and skeletal deformity. These three types should not pose a problem in the differential diagnosis of child abuse. Type IV osteogenesis imperfecta is less severe and the sclerae may be normal. Fractures in this type of the disease could possibly be mistaken for inflicted injury. About 5% of all cases of osteogenesis are type IV. Many will have a family history of osteogenesis or dentinogenesis imperfecta. Dr Taitz calculated the incidence of type IV disease with no family history and normal sclerae to be between one in a million and one in three million. He postulated that the absence of multiple wormian bones on skull x ray film after the newborn period virtually excludes the diagnosis.

It is now possible to diagnose osteogenesis imperfecta by analysis of type I procollagen in skin fibroblast cultures and workers in Tucson, Arizona (Sheila Gahagan and Mary Ellen Rimsza, *Pediatrics* 1991;88:987-92) have described three children who were thought at first to have suffered non-accidental injury but who were shown in this way to have osteogenesis imperfecta type IV. One of these children, however, had blue sclerae, one was thought unlikely to have accidental injuries on clinical and social grounds, and one had a sibling with osteogenesis imperfecta and had suffered fractures while in the care of several different people. There were, therefore, good clinical reasons for rejecting a diagnosis of non-accidental injury in all three cases and they do not detract from Dr Taitz's contention that it is possible to exclude the suggestion of brittle bone disease in almost all cases with a good history and clinical and radiological examination. Where there is genuine doubt collagen analysis may in future provide an answer but it should rarely be necessary.

ARCHIVIST

1 Taitz LS. Child abuse and osteogenesis imperfecta. *BMJ* 1987;295:1082-3.