CHILD AND ADOLESCENT MENTAL HEALTH SERVICES: RECENT DEVELOPMENTS

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INTRODUCTION

The profile of child and adolescent psychiatry has been raised considerably at a national level over the last few years, following the publication of a series of significant reports outlining the need for and emphasising the generally patchy and inadequate provision of appropriate professional services. The most thorough of these reports was "Together We Stand" produced by the Health Advisory Service in 1995, which advocated a better-organised, tiered system of professional services, starting at Tier 1, where help is provided by primary care staff such as GPs, health visitors and school nurses, and moving through to Tier 4, which includes very specialist resources such as inpatient units for either children or adolescents, usually only available on a supradistrict or regional basis. Most health districts provide something between Tiers 2 and 3, Tier 2 implying one or more specialist mental health professionals, tending to function more or less autonomously, and Tier 3 a better-resourced multidisciplinary team with the potential for joint work with particular families, especially those with more complicated problems.

At the time I came to this district six years ago, Lancaster and Morecambe had a rather odd combination of a well-established well-organised children's inpatient unit serving several adjacent health districts (Tier 4), and an outpatient service very much stuck at Tier 2, with only seven sessions a week of my time, and support from the current rotating registrar or SHO to tackle all the outpatient work for the full age range (0 to school-leaving age). South Cumbria's service was even more basic, with four sessions a week of my time and equivalent support from the current trainee. Things have developed considerably over those six years and at a pleasing rate, especially in the last two years.

To start with, our best-established asset: Red Oak, the children's inpatient unit. It was our good fortune to have been originally on that part of the Lancaster Moor Hospital site

Entrance to Red Oak House

Rear view, Red Oak, showing games area

destined for closure, providing the exciting opportunity of sharing in the planning and design of a new purpose-built unit away from the hospital site but still central enough to be easily accessible by our users. We moved in during September 1993, and the new building is in constant and steadily increasing use. Our twelve beds for under 12-year-olds are in great demand, not just from the usual districts of Lancaster and Morecambe, South Cumbria and Blackpool, but also Blackburn, Burnley, Wigan, Skelmersdale and, most recently, Bolton. Some of this increased demand from the more distant districts arises because some of the newer children's inpatient units elsewhere in the North-West have now closed. It can be difficult to meet this demand, and there is always a long waiting list, especially for boys with severe and long-standing behaviour problems associated with some degree of educational difficulty. The inpatient unit continues to be well managed by a dedicated team of specialist nursing staff. Morale is high and there is an ethos of continuing professional development and training: usually one of the nursing staff is on a postgraduate training course. Lancashire Education Authority continues to provide high quality specialist teachers, but when our most experienced teacher retired in July 1995 we were not allowed a replacement, so that the three remaining staff have to spread their expertise that much more thinly.

So much for Tier 4, which goes from strength to strength.

What of Tier 2 or 3 provision? Things have developed there, too, although we would still be more accurately placed at Tier 2 rather than 3. In 1993 a new post was created for a full-time clinical psychologist, to which Alastair Kennedy was appointed. He functions autonomously and can feel rather isolated and embattled by the demands made on him, but a system of regular meetings with the community

paediatricians (now two in the district) and the psychiatry team goes some way to helping with that. He has given priority to providing consultation and training sessions for health visitors and also to psychological input to acute and community paediatrics, as well as accepting direct referrals in the usual way.

Since 1995 the outpatient psychiatry team based at Red Oak has grown by three, plus one session each week from a community paediatrician. The first clinical nurse specialist (Community Psychiatric Nurse) for children and young people, Mick Dunn, started in September 1995, making a sideways move from many years' experience as ward manager of the inpatient unit. He is on the point of completing a training in Gestalt psychotherapy, making him our first properly trained psychotherapist. He takes his own caseload, predominantly of adolescents, but is also one of the three-person family therapy team. The second CPN post was also filled from the inpatient team in August 1996 by Kairen Creighton, whose special interest is the behavioural management of younger children. An unexpected but happy further addition to the outpatient team came in October 1996 with the arrival of Peter Stepanek, a qualified psychiatrist wishing to work part-time in child and adolescent mental health. His five sessions as a permanent clinical assistant have made a valuable contribution, and he has also joined the family therapy team. Mention should be made of our two skilled creative therapists: Janice Clarke, primarily trained in drama and person-centred counselling, and Julie Challis, an art therapist. Both are experienced in play therapy and group work, so between them have a range of skills to offer. Unfortunately, both are part-time and need to give priority to our current inpatients, leaving only a small amount of time for outpatient work. Nevertheless, they give what time they can and we look forward to the future when more of these skills will be available.

Play area, Red Oak

Meanwhile, what of South Cumbria? For some time, progress was slow. In 1992 a specialist social worker was appointed to work half time in child and adolescent psychiatry, which provided the beginnings of a team. Then in 1996 a full-time CPN in child and adolescent mental health was appointed and until the end of that year was the only full-time member of the team. Finally, some three years later than originally planned, a full-time consultant colleague, Dr Vincent Nathan, was appointed and took up his post from 30th December 1996. Development is now proceeding apace,

Interview room – Note the two-way mirror and the adult mannequins used for interviewing children who may be victims of possible sex abuse.

thanks to the combined energies of Mike Bone, Chief Executive of the South Cumbria Community and Mental Health Trust, and Dr Nathan, with impending appointments of two full-time specialist social workers and a second CPN. Regular clinical sessions have also been made available with an experienced clinical medical officer.

Readers might wonder if we have enough work to do with the advent of all these additional staff! Of course, as is always the case, the demand goes up constantly, partly due to a better known, more readily available and, hopefully, better appreciated service. Referral rates rise steadily, but re-referrals, especially of our most complicated, multiple-problem families, represent a significant proportion of the workload. In addition to these 'ordinary' referrals, we are experiencing, together with the rest of the country, a consumer-led phenomenon in the form of very many referrals seeking confirmation of and treatment for attention deficit/hyperactivity disorder. This is a somewhat controversial area, raising anxieties about following the American experience of over-diagnosis and overuse of stimulant medication, but a growing realisation is the way in which, if we take care about assessment and diagnosis, some children's lives are transformed by medication. The task is to sort out the genuine cases from those seeking to jump on the bandwagon. As children on stimulant medication need long term follow-up, there are considerable implications of large numbers of such children coming through, and an already stretched service can easily be swamped. In Lancaster and Morecambe, we are tackling this issue by planning jointly-run special AD/HD clinics, four per month, the work to be shared by the two community paediatricians, the clinical psychologist and the consultant and clinical assistant in child psychiatry, with support from one of the local educational psychologists.

Another initiative from Red Oak is that of running parent-training courses, especially for those parents of younger children who find appropriate management of the children's behaviour difficult. These are run in ten-week blocks by two of the senior nursing staff, and after some difficulties finding the best venue and time, the interest and take-up has been steadily improving and they have become well-established. Some, but not all, of these parents have children who are referred to the service.

There is a lot to be done – one wonders if we will ever fully meet the demand, but the hope is that with more and

Red Oak staff

more personnel, all keenly enhancing their own professional skills, we shall be able to develop more of these treatment/management programmes.

What is very sad is the way in which so many children seem to get into emotional or behavioural difficulties. Some epidemiological studies quote a figure as high as 20% of all children and young people having significant psychological disturbance. There are still far too many children experiencing abuse of one kind or another, and the consequences of this can follow them for years. The two most common contributory factors in many of the children we see are family breakdown and some degree of educational failure or difficulty, making it hard to fit into the mainstream school system.

Adolescents in particular are not well-served throughout the country, but especially in the North-West. When they develop disorders severe or worrying enough to indicate admission to a psychiatric unit, there is nowhere nearer than Manchester, and far too few places to go round. This lack of appropriate provision leads to enormous anxiety for families and professionals alike, especially in cases of major mental illness such as suicidal depression, acute psychosis and severe eating disorders.

All in all, it seems unlikely that we shall run out of 'customers' in the foreseeable future, but if the service continues to develop and expand its repertoire of helping strategies at the recent rate of progress, hopefully we may manage to limit some of the longer-term consequences for today's troubled children.