THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION

THE RECRUITMENT AND TRAINING OF THE CHILD PSYCHIATRIST

(Approved by Council 11 February, 1960)

The Child Psychiatry Section of the Royal Medico-Psychological Association, which is the professional body of child psychiatrists in this country, considers the present to be an eminently suitable time for a reassessment of the recruitment and training of child psychiatrists.

As a result of the Report of the Committee on Maladjusted Children, circulars have been issued by the Ministry of Health and the Ministry of Education, making recommendations in the fields of child guidance and child psychiatry. The implementation of these circulars will call for an expanded service, and hence an increase in the establishment of child psychiatrists. Again, the Mental Health Bill is a stimulus to psychiatry generally and will lead to an expansion of the Mental Health Services. The Royal Medico-Psychological Association is desirous, not only of attracting a sufficient number of trainee child psychiatrists into the field, but also of attracting doctors of high ability into the field of child psychiatry and making it possible for them to receive a sound training so that consultant appointments will attract applicants of adequate training and experience.

The supply of child psychiatrists was reviewed by the Royal Medico-Psychological Association in a comprehensive document in 1951 (1). A brief memorandum was also addressed to the Ministry of Health in June, 1955 (2), and the helpful attitude of the Ministry at that time has encouraged the Royal Medico-Psychological Association to review the matter again.

In considering the functions of child psychiatrists reference should be made to the memorandum of the Royal Medico-Psychological Association published in 1951 (1). The views expressed therein have been amplified by two later documents (3, 4). Briefly, these functions include clinical work in out-patient child guidance and child psychiatry clinics, clinical work in in-patient units, teaching, research, and preventive work in the community. Work with the pre-school child, the school child, the adolescent, and the parents is involved.

Supply of Child Psychiatrists

(a) *Estimation of the number required.*

The population to be served in England and Wales is approximately 40,000,000, in Scotland approximately 5,000,000 and in Northern Ireland approximately 1,000,000.

After careful consideration and enquiry of its members, the Royal Medico-Psychological Association regards a realistic minimum estimate to be, that one full-time, trained child psychiatrist, with complementary junior psychiatric staff, is required per 200,000 of the population, i.e., 200 child psychiatrists for England and Wales, 25 child psychiatrists for Scotland, and 5 child psychiatrists for Northern Ireland—*a total of 230 child psychiatrists.* But future experience will probably show that this is an under-estimate of the minimum number required.

(b) *Numbers available*

(i) *Consultants and S.H.M.Os.* The Underwood Report (5) estimates that in December, 1954, there were the equivalent of 56 full-time psychiatrists employed by local authorities and that in December, 1951, there were 39 psychiatrists employed by the hospital service, the total, therefore, being 95 full-time child psychiatrists.

An analysis now by the Royal Medico-Psychological Association of the

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directory of child guidance clinics published by the National Association of Mental Health in 1958 showed that, at an optimistic estimate, the equivalent of approximately *160 full-time child psychiatrists* were being employed in local authority clinics, hospital clinics, and teaching hospital clinics in England, Wales, Scotland and Northern Ireland. Not all these psychiatrists were graded as consultants.

An R.M.P.A. survey of 1953 throws some light on the grading of child psychiatrists. Of the 89 child psychiatrists who replied to a questionnaire, 68 were consultants, 18 S.H.M.Os., and 13 were ungraded. Two-thirds of those in charge of local clinics were consultants and all those in charge of clinics in teaching hospitals were consultants. It is the policy of the Royal Medico-Psychological Association to advocate that any psychiatrist in charge of a clinic should be graded as a full consultant.

An analysis of the advertisements for the four years 1950-53 showed that there was a tendency for a disproportionate number of S.H.M.Os. to be appointed. This is to be deprecated, especially since it has led to S.H.M.O.s being left in charge of clinics, and because it has had a most adverse effect on the recruitment of child psychiatrists.

(ii) *Senior Registrars.* A Royal Medico-Psychological Association estimate of 1955 showed that there were four and a half senior registrars unevenly distributed outside London, and six senior registrars in London, making ten and a half senior registrars in England, Wales and Scotland. Since then it is estimated that approximately five additional senior registrar appointments have been made. Thus there is a total of *approximately 16 senior registrars* in child psychiatry.

The table made available by the Ministry of Health and the Department of Health for Scotland in 1958 (*British Medical Journal, ii,* Supplement, p. 139) showed that the ratio of training posts to consultants in mental health generally, is approximately 1 to 5, and in all specialties *1 to 6.* From the data given above it will be seen that the ratio in child psychiatry is 16 to 160, i.e., *1 to 10.*

(iii) *Registrars.* A Royal Medico-Psychological Association estimate in 1953 showed that there were 3½ registrars in the provinces and 16 in London, making a total of 19½ registrars engaged in child psychiatry throughout England, Wales and Scotland. This grade is not normally suitable for trainee child psychiatrists, but offers an opportunity for a psychiatrist undergoing general training to have training in child psychiatry.

(c) *The Need for Training Posts*

Training posts are required in child psychiatry for the following reasons:

(1) To maintain the present number of child psychiatrists, by making good the losses through death, retirement and transfer.

(2) To make up the backlog and provide for the optimum number within the next five years—the longest period that can reasonably be allowed for the task.

(3) To provide extra consultants in teaching clinics.

(4) To make some consultants available for clinical research in the field.

Earlier in this document it has been estimated that a minimum of 230 child psychiatrists is required, and that approximately 160 are available. Thus *70 additional senior posts* are required.

It is assumed that 16 senior registrar training posts are established at the moment. The addition of 24 senior registrar posts would make a total of 40 senior registrar training posts. Training takes three years, and thus about 14 child psychiatrists would be produced per year. In five years approximately 70 child psychiatrists would be forthcoming, and this with the existing 160 child psychiatrists would make a total of 230 child psychiatrists, which is the desirable optimum

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number, making the ratio of training posts to consultant posts 40 to 230, i.e., *nearly 1 to 6*. The above figures do not take account of the need to make good the losses due to retirement, etc., during the next five years, and this factor together with the time required to establish new training posts may cause the programme to extend beyond the five years suggested above. However, the programme may be helped by the candidates who, exceptionally, may be so qualified that they can complete their training in less than three years.

The 24 extra training posts could be provided by doubling the number of existing senior registrar posts in clinics already offering training facilities, and by creating training posts where there are suitable facilities in other clinics. There are grounds for believing that recruits are forthcoming. The extra 24 posts will need retention at the end of the five year programme so as to maintain the desirable ratio of training posts to consultant posts at 1 to 6. The position should be reviewed at the end of a further five years.

(d) *Recruitment*

The majority of child psychiatrists are likely to be recruited from the field of general psychiatry. Thus all the factors affecting the recruitment of general psychiatrists eventually impinge upon the recruitment of child psychiatrists. These include the changed attitude of the public towards psychiatry, the sounder training in psychiatry for medical students, training facilities, the availability of posts in general psychiatry, and the equitable distribution of merit awards.

In addition there are factors more directly related to recruitment into child psychiatry. These include the opportunity for some training in child psychiatry for the medical student, the availability of a period of training in child psychiatry extending over at least six months for the general psychiatrist, opportunities for promotion equal to those in other professions, availability of training posts in child psychiatry, proper conditions of clinical work, and opportunities for original work in this field.

It is known to the Royal Medico-Psychological Association that excellent recruits have been obtained in the past from paediatrics, public health, general practice and general medicine. Every encouragement should be given to facilitate transfers from these disciplines, although it is emphasized that training should take place in two stages:

(1) A comprehensive training in general psychiatry, with particular attention to the understanding, management and treatment of the neurotic patient.

(2) Specialized training in child psychiatry.

Training

This has been outlined in detail in the memorandum of 1951 (1).

The memorandum envisaged a comprehensive basic training in general psychiatry at the senior house officer and registrar levels. Specialization in child psychiatry should normally take place at the senior registrar level and a three year period of training at this level was recommended.

In the years since this memorandum was published experience has shown that particular attention must be paid to training child psychiatrists in the understanding and treatment of the psychopathology of both the child and the adult neurotic patient.

The specialized training required at the senior registrar level for the trainee child psychiatrist should be undertaken at clinics orientated towards teaching and research, which are able to offer a comprehensive training, with a consultant child psychiatrist in charge, and with the clinic having sufficient staff to allow adequate time for the supervision of its trainees. The establishment of consultant psychiatrists in training clinics should be greater, in order to allow time for teaching.

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Recommendation

In order to produce the desirable optimum number of child psychiatrists in the next five years the Royal Medico-Psychological Association recommends the immediate establishment of 24 additional senior registrar training posts in child psychiatry.

References

(1) Memorandum on the Training of the Consultant Child Psychiatrist, 1951. Royal Medico-Psychological Association.
(2) Memorandum on Training Facilities for Consultant Status in Child Psychiatry in Great Britain, 1955. Royal Medico-Psychological Association.
(3) Organization of Psychiatric Services for Children and Adolescents, 1956. Royal Medico-Psychological Association.
(4) Memorandum on the Report of the Committee on Maladjusted Children, 1957. Royal Medico-Psychological Association.
(5) Report of the Committee on Maladjusted Children, 1955. Ministry of Education. H.M.S.O.

MEMORANDUM ON UNITS FOR THE LONG-TERM MEDICAL CARE OF EMOTIONALLY DISTURBED CHILDREN AND ADOLESCENTS

(Approved by Council 3 May, 1960)

In September, 1956, the Child Psychiatry Section of the Royal Medico-Psychological Association in its memorandum on "In-Patient Care of Child and Adolescent Psychiatric Patients" dealt in detail with the provision of units for the short-term investigation and treatment of children and adolescents. It also drew attention to the need of "increased provision of long-term substitute home care for disturbed children" and "improved provision of after-care hostels for adolescent patients" as was forecast in Section of 17 of the National Health Service Act, 1946, and in the memorandum to Regional Hospital Boards (47) 13, para. 38.

It is being increasingly recognized that the adequate care of adult psychiatric patients requires, in addition to hospital in-patient and out-patient units a variety of establishments not previously considered essential, in particular the day hospital, the hostel, and the protected workshop. A corresponding range is required for children and adolescents. The Child Psychiatry Section considers that the stage has now been reached for further thought to be given to the provision of units for the long-term medical care of disturbed children and adolescents, and as a start, the setting up of one or more such units as prototypes.

The Problem

We are concerned with children whose needs are not appropriately met by schools for maladjusted children nor by in-patient treatment in a Children's Psychiatric Unit. Some may not have needed admission to an in-patient ward in the first place; others may have had a period of in-patient treatment and made a partial recovery.

The children we have in mind are likely to respond slowly to care and treatment and to need progressively a less medical setting.

They are not a homogeneous group. There will be a considerable range of age and intelligence although the severely sub-normal child is not here included. Some are children with some abnormality of brain structure or biochemical disturbance; some have been seriously affected by psychological or social disturbance; many have elements of both. These children may show such symptoms as bizarre behaviour, the restlessness and fantasies of the deeply disturbed, running away, impulsive acting out of sex problems and fire-raising which make them unsuitable for a school.

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