

opinion & debate

Psychiatric Bulletin (2000), **24**, 370–371

ANTHONY EDWARD LIVESEY

W(h)ither child psychiatry?

The impact of primary care groups and trusts on the future of child and adolescent mental health services

There is considerable variation in the levels of child psychiatric provision across Europe (Remschmidt & van Engeland, 1999). The recent European Society of Child and Adolescent Psychiatry meeting in Hamburg (September 1999) provided many examples of the differences in provision of service, as well as training and status of professionals working in the field. It also highlighted major differences in philosophical and theoretical models used in different countries.

Given the very different histories that have pertained in these countries and services, these differences are of interest but will hardly give rise to surprise. What is of more pressing interest and concern in Britain is the variation in provision of child and adolescent mental health services (CAMHS) in different districts and regions here, and the effect of current changes underway within the NHS, which will exaggerate, not lessen, the disparities that currently exist.

In 1998 the Faculty of Child Psychiatrists undertook a survey of its members on where our CAMHS are, or should be sited, in managerial terms. Approximately 50% of CAMHS were allied with child health and 50% with mental health services (details available from the author upon request). The Faculty concluded that there could not be one prescriptive solution suitable for all districts because much depended on the local relationships with colleagues within other disciplines, and the relative strengths and weaknesses of local management groups.

It is now time to take stock of the rapidly changing situation if we are to be in a position of informed strength, rather than reactive panic. We should also fear apathy, which represents just as great a danger to our services and our patients.

I know of no recent survey or census that describes the nature of the trusts that employ us. We find ourselves in acute hospital, mental health or community trusts. Although 94% of services are community-based (Child and Adolescent Mental Health Services, 1995), this does not necessarily equate to being employed by community trusts. This situation has been changing slowly as trusts have merged (with an emphasis on larger trusts, considered to be economically advantageous), but change of a more dramatic nature is about to overtake us.

Primary care groups (PCGs) have been established, and there is considerable pressure for these groups to move rapidly to become primary care trusts (PCTs). Such trusts will not only commission services, but deliver them and employ the staff required to do this. This change may seem rather distant and esoteric to many practitioners, but I suggest it will have an impact on our services that will be considerably greater than that of the inception of trusts 7 years ago.

The factors that fuel my concerns are as follows. The wishes of doctors in primary care are likely to take second place to the pressure from above, delivered through the chief executives of the PCGs, to move to PCTs.

This move will impinge only marginally upon acute hospitals, which will continue to deliver their services largely unaltered, albeit those services will be commissioned by the PCTs, rather than the health authorities.

Community trusts, however, will see a considerable portion of their work (e.g. health visitors, primary care nurses etc.) pass seamlessly to the PCT and with it a large number of their staff. This will leave those specialist or secondary services, and among them many CAMHS services. Their choices are limited, though it may be presumptuous to assume they will be offered a choice.

Few such specialist services will be of a size to enable them to become a trust in their own right, without joining with services in adjacent districts. They may find a home within acute or mental health trusts and such a solution may prove secure and fruitful, or they may be disseminated among the PCTs. This option amounts to being cast to the four winds and the possibility chills me to the bone. Cooperation with other disciplines would be impeded and individual CAMHS may prove too small to be viable in the longer term. Further, I am concerned that within a PCT we would be neither sufficiently understood nor valued, thus divided and alone, and some of our services could expire.

CAMHS services are complex and do not easily fit into a simplistic acute health service model. We link and relate to more disparate services and professional groups than almost any other service within the health sector. However, this leaves us vulnerable to fragmentation by those without sufficient understanding of our services, and with a less than complete interest in coming to a better understanding.

The PCG to PCT transition is being managerially driven from above, and currently owes little to any clinicians' views. With PCG chief executives in place, their performance objectives could be structured so that delivering this transition becomes their top priority. Were this the case, then consultation exercises would be late, perfunctory and tokenistic.

The disparity in the range of CAMHS services in this country should give rise to both surprise and concern, but it doesn't. Rather, it is in danger of becoming accepted and acceptable through familiarity. Many health

https://doi.org/10.1192/pb.24.10.370 Published online by Cambridge University Press



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improvement programmes highlight the objective of equitability of access to services. However, the involvement of clinicians in health improvement programmes is often minimal, and the programmes themselves have yet to prove their value.

The process of structuring futures is already underway, but largely behind closed doors, and, more importantly, with little clinician involvement. These changes will result in a considerable reshuffle of middle and senior managers' jobs, and it would be naïve to presume that personal, as well as clinical, futures might not influence the debates.

Moving from concerns, to solutions, it is clear that a simplistic 'one size fits all' prescription is neither possible nor desirable. However, the changes present an opportunity to rethink and restructure CAMHS to advantage, if we can harness the momentum.

It is crucial that child and adolescent psychiatrists are aware of the current situation and are willing to act. Local knowledge of the PCG and evolving PCT structure and the position of other clinicians is extremely important.

Next, where are the debates taking place, and who is involved? If you cannot win a place at the table, do you have the ear of one who does?

Finally, local clinicians need the support of our Faculty, which could provide a useful monitoring and informing role. It would be helpful, if possible, to provide guidance and a strong central voice if a clarity of view emerges.

I would be happy for history to condemn me as a scaremonger. However, I fear that Cinderella doesn't know there's a ball being planned, let alone how to get a look in.

References

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Anthony E. Livesey Consultant Child Psychiatrist, Marsden Street Clinic, Marsden Street, Chesterfield, Derbyshire S40 1JY

https://doi.org/10.1192/pb.24.10.370 Published online by Cambridge University Press