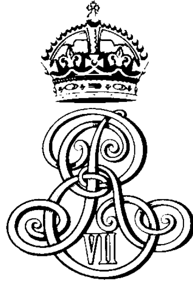

Child and Adolescent Psychiatric Services in West Lambeth Health Authority

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Child and Adolescent Psychiatric Services in West Lambeth Health Authority

Report of a visit on

25 and 26 July 1988

1. Introduction

An advisory team was convened by the King's Fund Centre to offer the West Lambeth Health Authority advice on the future of its child and adolescent psychiatric service. (Membership at Appendix A). The terms of reference for the team are set out at Appendix B. The team visited the Health Authority on the 25 and 26 July, and were able to talk with a wide range of health authority staff as well as health authority members and representatives from other organisations. (See Appendix C) We were provided with a number of background documents which are listed at Appendix D.

The team visited the three main sites where child and adolescent psychiatric work is carried out but clearly in the time available could not see the full range of work in any of these. We were impressed with the motivation and commitment of the staff to the service currently provided but also with their concern to be as effective as possible in meeting the needs of the population they serve. Inspite of the shortness of the visit, through the cooperation of staff we believe we were able to gain a good impression of the range and depth of services, and we believe we have addressed the questions in the terms of reference, but not necessarily within the framework they were set.

We have tried to keep our report as short as possible, and to confine our recommendations to what we see as the key issues. More time might have enabled us to be more detailed in our recommendations but in any case we feel that the details of subsequent improvements can be generated only from within the staff themselves.

In considering services offered by West Lambeth Health Authority, we had in mind our view of a model or standard service for child and adolescent psychiatry in any district. We feel it may be helpful to specify in outline the nature and objectives of this service. We have done so in Appendix E, and hope it will enable those unfamiliar with such services to understand our approach to the quality of the service and the basis of our recommendations.

2. The current service

In reviewing the service we were aware that there is a history stretching back many years of discussions on and strategic development of the child and adolescent psychiatric service. To some extent this has resulted in several issues becoming confused in the minds of some staff. In an attempt to clarify the position we identified four key issues:

(i) financial resources

(ii) quality of service

(iii) the management arrangements

(iv) the proposed family resource centre.

Although these issues are clearly interlinked we feel that dicussion is helped by addressing them individually.

3. *Finances*

We are concerned about the reliability of the financial data provided for us in the consultation document, and there seems to be confusion in the minds of some staff whether the budget relates to the service as a whole or solely to the facilities at Black Prince Road. We have assumed that the budget relates to the whole service.

The budget has been set for 1989 at £300,000 and therefore this represents the maximum revenue saving for both the acute unit and the district. Alternatives 1 and 2 in the consultation document both save £300,000 for the acute unit and £250,000 and £200,000 respectively for the district as a whole. Some staff appear to be confused with regard to the budget for the proposed family resource centre. As we understand it this will be funded with money allocated from development funds and money from the Inner City Partnership Scheme (although we were told this latter has not yet been finalised, and in any case it would last for only three years). Although the resource centre does not therefore involve additional net district revenue expenditure it may have capital cost implications unless existing facilities are adapted to make them suitable.

Our view on the funding of the service is that to make any significant savings would seriously compromise the work of the child and adolescent psychiatric services in such a way as to make it non-viable in providing anything approaching the current service. We have looked however at what savings could be made whilst retaining the overall structure, but would emphasise that these savings would be very modest, compared with the savings outlined in the consultation document.

(i) The reduction of one sister's post at Black Prince Road. **Saving c. £15,000**

This would involve the senior nurse doing more case work, and the service for older children being restricted to specific treatment sessions with the loss of the general support available to them at other times.

(ii) Abolition of the basic grade occupational therapist. **Saving c. £10,000**

Apart from the important loss of O.T. training opportunities this would result primarily in a reduction of the service to the St Thomas' site, as well as to the day hospital at Black Prince Road.

(iii) A limit to the range of creative therapies. **Saving c. £5-10,000**

We are uncertain how much money would be saved as we do not have the data available but it would certainly be small and would change significantly the nature of the service.

(iv) A reduction in one community psychiatric nursing post. **Saving c. £15,000**

This would involve a reduction in the service offered in the community, which we have been told is already inadequate.

However, we believe that whilst financial ***savings*** may be difficult to achieve there is considerable scope for increased ***efficiency*** of the unit in the medium term and therefore a greater output for the given cost. Apart from the initiatives we discuss in the next section, regarding practices within the unit, achieving this efficiency will involve looking further at the range and mix of staff, as well as addressing the lack of facilities to which children are discharged and the lack of day nursery services in the community.

4. *Quality of Service*

The ultimate assessment of quality of the service must be in terms of personal outcomes compared with the demand within the population. West Lambeth, in common with almost all other districts does not have firm data on the need within its population, but we were surprised by the absence of any aggregated or easily available data on the service provided (see footnote †). This applies not only to outcomes but also to overall numbers, case load, treatment provided and follow-up. In the absence of these data it is impossible to make robust statements about efficiency and effectiveness and we are limited to opinions based on anecdotes or subjective impressions. It is important to point out that if ***we*** are unable to make such statements then the service itself is similarly handicapped, and this is apparent in the relative failing to communicate widely the value of the work undertaken. Furthermore it follows that the staff do not possess the tools with which to examine their own work and make appropriate improvements to the services offered. This needs to be rectified as a matter of urgency.

Overall we were struck by many successes of the present arrangements in providing a service for the local community. In particular:

(i) The Unit assesses and treats a broad spectrum of disorders over a wide age range.

(ii) There is an established multi-disciplinary approach, with a highly developed community psychiatric nursing role.

(iii) Facilities are provided for treating a wide spectrum of severity of disorders in children, with a highly valued and well developed service for multiply deprived and disturbed pre-school children and their parents.

(iv) There is a good network of links with other agencies (inside and outside the health authority) which deal with disturbed children.

(v) There are very close, valued relationships with the Consultant Paediatricians.

(vi) There is good training for junior medical staff and a commitment to in-service training for other staff.

(vii) There are considerable successes in developing the community clinic at Mawbey Brough which carries a considerable caseload and has a good network of links with other agencies, with the outreach work in training and supporting professionals in other agencies being well received.

† Dr Roberts has now kindly sent some more detailed data he has since worked out. They confirm our view that the consultation document understates the workload on the service, relying as it does on routinely collected data relating to medical activity.

However, against these successes need to be noted some shortfalls:

a) There is only a narrow range of treatments available with the emphasis on individual long term psychotherapy. We were concerned with the lack of:
   (i) short term interventions
   (ii) behavioural methods
   (iii) family therapy

   We feel that these should be offered alongside existing treatments, and would together constitute a good comprehensive treatment approach.

b) There are no treatment facilities for severely disturbed adolescents. This is probably a Regional problem, but needs to be identified within West Lambeth.

c) There is considerable scope for improved multi-disciplinary working, for example through referral meetings and case discussions. The potential contribution of social workers, occupational therapists and clinical psychologists within the multi-disciplinary team seems to be undervalued.

d) There are unacceptably long waiting lists for both psychiatric assessments and treatment of sexually abused children. We do not feel it is acceptable to place children on a waiting list of over one year, as by then the treatment may have become inappropriate. Preferably some less intensive support should be given to them whilst they await more specific treatment. Consideration should also be given to offering treatments of shorter or less intensive duration in order to enable more children and their families to be helped.

e) There seemed to be a low through-put at Black Prince Road, probably reflecting the bias towards long term treatment methods. By the end of their treatment some children are using valuable staff resources more as a day nursery. These problems need readdressing, perhaps through the development of an operational policy.

f) There is a worrying absence of data on the service provided. With the absence of these data it is difficult to see how any satisfactory continuing evaluation and review of the service can be achieved. We think that this as part of the educational process should be strengthened. We believe the service should be more active in describing its work, perhaps through the publication of an annual report.

g) There is little cover to the south of the district (although this may be in part compensated for by services in adjoining districts). Arrangements with the adjoining districts should be specified in more detail.

5. Management Arrangements

i) **Internal**

There appears to be a lack of management in the sense of operational policies, priority setting, definition of aims, and leadership across the service, although in some discreet areas of work priorities had been set. We were unsure even at the end of the visit of the roles of several key staff and formed very strongly the impression that other staff shared these uncertainties. It was not clear to us which direction the service saw itself going nor did we feel that there was any internal understanding of management issues.

It is unclear, who is responsible for managing the child and adolescent psychiatric service as an entity. The managerial roles of consultant medical staff, and the senior nurse should be clarified. We believe this is best achieved through the recruitment of an identified manager, who would probably be a health professional with the relevant ability and experience to manage change.

ii) **External**

We were aware of strongly held and differing views as to whether the service should be located within the acute or community unit. Mostly these views were assertions of the importance of close relationships with one or another related service. Whilst we acknowledge the importance of all these relationships we were not persuaded that any one was more important than any other, but that wherever the unit is managed it is important that links with related services are fostered and maintained. We therefore did not think there was any good argument for locating the service in either unit, but were impressed with the strength of feeling most of the current staff expressed in preferring the acute unit. We did not see any advantage therefore in changing this management arrangement as it would necessarily involve considerable negotiations with staff.

6. Family Resource Centre

There appears to be some overlap between the work of the proposed family resource centre and the service currently provided but we were not convinced that the family resource centre offered the health authority any service which either could not be provided within the child and adolescent psychiatric service or was primarily the responsibility of social services. We are sure that there exists a small but important group of children with severe behaviour disturbances or psychiatric illness whose needs would not be met by the family resource centre and for whom the health authority, if it were to close the child and adolescent psychiatric service as it currently exists, would have to make re-provision. It is difficult to see how the health authority could do this at a substantially lower cost than the current service. Given its current financial difficulties, we are not convinced that the health authority should give the resource centre a high priority, without further information on the benefits and costs.

7. *Key recommendations:*

(i) That the West Lambeth Health Authority should maintain the child psychiatric service in broadly the same form as currently provided. If there do need to be some financial savings made within the service then the Authority should consider restricting services for older children at Black Prince Road to specific therapy sessions, saving one qualified nurse post, or reducing the community psychiatric nurse staffing with the loss of some coordination and preventative work.

(ii) The Authority should appoint or identify a manager for the service who will be given the responsibility for making improvements to the efficiency of the unit in the areas we have identified, in extending the range of treatments and for documenting the work, perhaps through an annual report.

(iii) We do not believe that the Authority would gain by moving the service to another unit of management. If other considerations argue in favour of such a move the Authority will need to negotiate this carefully with a wide range of staff.

(iv) If the Authority is keen to develop the family resource centre it will need to identify service gains more accurately before committing itself.

APPENDIX A

Team Members

David Costain,
Director, Acute Services Project, King's Fund Centre

Gillian Forrest,
Consultant Child Psychiatrist, Park Hospital, Oxford

Marjorie Gardiner,
District Occ.Therapist, Warneford Hospital, Oxford

David Postlethwaite,
Nurse Teacher, Fulbourn Hospital, Cambridge

Ray Robinson,
Health Policy Analyst, King's Fund Institute

Chrissie Verduyn,
Principal Clinical Psychologist, Bolton General Hospital

APPENDIX B

Terms of Reference

- To identify a service structure which provides essential psychiatric care to West Lambeth District children and adolescents. It is accepted that this may not provide an ideal level of service given the Health Authority's financial constraints.

- To consider other Health Authority services related to child and adolescent psychiatry which are currently provided within the District (e.g. relationship, 'value', to psychiatric service).

- To review and comment on the current child and adolescent psychiatric services which are provided by the acute unit in terms of effectiveness and 'value for money'. To comment on the human and material resources currently devoted to child and adult psychiatry (i.e. those resources particularly attached to the 'Black Prince Road' Acute Unit budget) and on any gaps in the service.

- To make recommendations on the current service which may or may not be finance related (e.g. organisation, management approach/structure, operational policy, activity/management information availability, communication, relations/links with other related services, outcomes).

- To review and comment on the proposal of providing an alternative service through the community unit (considerations: feasibility, service gaps etc).

- To consider other service alternatives which are possible on a reduced resource base.

APPENDIX C

List of individuals who presented their views

Rosemarge Aldridge	Administrator, Clinical Services
Dr Allsop	Senior Clinical Medical Officer
Mrs Bernstein	District Psychologist
Ursula Brolly	CPN
Sarah Campbell	CPN
Alan Chandler	ILEA
Phyllis Clarke	District OT
Dr du Mont	Senior Lecturer in Paediatrics
Frances Favel	Sister CSA
Jane Foster	Sister under 5s
Dr Fowler	Senior Clinical Medical Officer
Dr E Frommer	Consultant Child Psychiatrist
Leo Garwe	Senior Nurse
J Hawkes	HA Member (supplemented by letter of 28.7.88)
Dr C D Heath	Senior Clinical Medical Officer
A Kuteck	Child Protection Coordinater, Social Services
Caroline Langridge	Unit General Manager (Community)
Sara Lythope	Senior Occupational Therapist
Dr P Moberley	HA Member
Tom Mountain	Porter
Mary O'Readen	Nursery Nurse
Jenny Perkis	Chairman, Community Health Council
Dr H F Roberts	Consultant Child Psychiatrist
Prof. J W Scopes	Consultant Paediatrician
Dr C M M Stern	Consultant Paediatrician
Liz Stevens	Director of Nursing Services
Irene Swan	Senior Nurse, Child & Family Unit, South Western
Jo Thomas	CPN
Brian Tosser	ILEA
Judy Tresseder	Head Social Worker, Sexual Abuse Team
Susan Wach	Acute Unit Planning Officer
Nick Wharan	Voluntary Sector Representative
Liz Winder	Unit General Manager (Acute)

APPENDIX D

Documents submitted to the Team

1. Consultation Document on the 'Proposed Closure of Black Prince Road Day Hospital and other Service Reductions in the Child and Adolescent Psychiatric Department and Alternative Service Provision' (June 88).
2. IACC (Yates) P I Package - Indicators for Child Psychiatry (March 88).
3. Data on Outpatient Activity in sites within West Lambeth and for NHS day care in the Child Psychiatry Day Hospital, Black Prince Road (March 88).
4. Letter to West Lambeth Health Authority from Dr Howard Roberts (April 88).
5. Letter to Mr J Garnett, Chairman, West Lambeth Health Authority, from Dr Graham Clayden, Senior Lecturer and Honorary Consultant Paediatrician (May 88).
6. Letter from Dr Stern to Liz Winder (July 88).
7. Child Psychiatry: a district service. Dr Benians. Published in Maternal and Child Health (December 1987)
8. Staff List Black Prince Road (undated)
9. Nursing Staff Structure. Department of Child and Family Psychiatry (undated).
10. Child Psychiatry Day Hospital Children on Register Map (March 88).
11. Map of West Lambeth HA Services (undated).
12. Draft of 'Development of Child and Family Psychiatry Proposals for Development of Services over the coming decade' (March 85).
13. Draft (10) of community child and adolescent psychiatry operational policy (undated).
14. Revised proposal for in-patient adolescent unit for inclusion in the 10 year plan (undated).
15. Consultative Revised Strategic Plan 1988-94 'A Programme for Action' West Lambeth Health Authority (May 87).

APPENDIX E

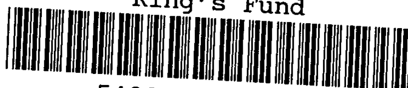
A model service

1. We believe that it is essential that any service should provide all the following:
   - (i) The assessment of children exhibiting disturbed behaviour, and of their families
   - (ii) The treatment of psychiatrically disturbed children and their families
     - a) within the age range 0-17 years
     - b) covering a wide spectrum or range of psychiatric disorders
     - c) offering a service flexible enough to be able to offer a range of the currently accepted treatment methods. These methods need to recognise the multi-disciplinary nature of the specialty in which the roles and contribution of different disciplines are clearly defined and valued. Treatments offered need to include both short and long term interventions and more than one model of psychological therapy.
     - d) and which is able to respond to the span of severity of disorders. This will require both out-patient and day-patient facilities and access to in-patient facilities when needed.
   - (iii) The service must be able to demonstrate its ability to work closely with other agencies concerned with the care of disturbed children in order to be able to anticipate and prevent serious disorders. At the least it will need good links with social services, children's homes and day nurseries, both mainstream and special schools, and and relevant voluntary agencies e.g. Dr Barbardos, NSPCC.
   - (iv) The service will need to have close links with other health authority services for children, especially primary care teams, clinical medical officers, child development teams and paediatricians.
   - (v) The service will need collaborative links with other agencies involved in child abuse and be able to meet its requirements for full participation in local child abuse services.
   - (vi) The service should provide training in child psychiatry for medical and other students, and staff may need to be seconded outside the district for this. It should offer training and support for staff of other agencies who deal with disturbed children.
   - (vii) Staff should be able to undertake continuing evaluation and review of the service provided with a view to improving both the clinical service and management organisation. They should also be able to use the data that are collated to contribute to future planning.
   - (viii) The service should have an organisational structure that facilitates these aims.

2 We consider that the following elements, whilst not essential, are highly desirable.

   There should be:
   - (i) Easy access to the service both geographically and in ease of referral. If treatment is suggested but is not available within a reasonable time then alternative support should be offered.
   - (ii) The service should offer some preventative work to identify potential problems by working in, for example, schools, obstetric departments and well baby clinics. In addition some secondary preventative work should be aimed at minimising the effects of long term psychiatric illness on the child.

3. We regard it as desirable that facilities for research into the type of problems seen should be available.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