Correspondence

Importance of social workers in the training of child psychiatrists

DEAR SIRS

We are writing to bring to the attention of the College the detrimental effects that the withdrawal of social workers from child psychiatry departments will have upon the training of child psychiatrists. In recent months there have been attempts, some of which have been successful, to redeploy social workers from multi-disciplinary child psychiatry teams to understaffed area offices. In child psychiatry departments social workers, with their particular training and accumulated experience, are an essential asset. Their importance for clinical services has been acknowledged elsewhere. Here we wish to explain why they have a role in training child psychiatrists.

Firstly, social workers have a training which includes the study of social administration, including the institutions of welfare and child care law. They are familiar with the local authority and judicial decision-making processes concerning children, care issues and social service departments. They contribute to the teaching, both formally and informally, concerning child care issues.

Secondly, they are usually trained in non-clinical settings and are employed by social service departments. Their model for working, the social model, is often different to that of psychiatrists. Since child and adolescent psychiatry requires consideration of the whole range of conceptual models, their contribution is, in clinical settings, complementary to good practice. In practical terms, the withdrawal of social workers from child psychiatry teams may mean that the other team members feel unable to accept referrals of patients with particular kinds of problem. This in turn may lead to a narrowing of senior registrars' clinical experience.

Thirdly, in many child and adolescent psychiatry teams the social workers are the most experienced and skilled family therapists. Co-therapy and supervision provide good opportunities for learning family therapy skills. Outside the post-graduate training institutions, and especially outside London, access to family therapy teaching and supervision for trainee child psychiatrists is limited. Furthermore, social workers often have specialised skills in other treatment techniques which contribute to senior registrar training.

Fourthly, in teaching hospitals especially, there is a rapid turnover of junior staff, and this means that permanent team members, such as social workers, have an important role in maintaining and transmitting the team ethos. How this happens is something which senior registrars, who regularly change teams to gain experience, have to learn for their work as consultants.

The threat to the place of social workers in psychiatric teams is occurring at a time of change in the organisation of education. One notable example is the uncertainty over the future of the Inner London Education Authority. This must place in doubt the future of London's child guidance clinics, where many trainees gain experience of multi-disciplinary work with social workers and other professionals. Furthermore, the uncertain future of ILEA also casts doubt over the participation of teachers in child psychiatry teams. Sadly, the trend appears to be towards greater homogeneity within child psychiatry teams, in that the professionals will tend to have received similar trainings and be employed by the same authority.

The importance of multi-disciplinary work in the training of child psychiatrists is recognised in the Child and Adolescent Psychiatry Specialist Advisory Committee (CAPSAC) recommendations that "trainees should have experience of working in a variety of settings and with the full range of related disciplines". We urge the College to apply pressure to the DHSS and other bodies so that its recommendations may be fulfilled. Without such changes a new generation of child psychiatrists will emerge who have had no experience of working in a multi-disciplinary team. The College will be considered to have failed in its responsibilities if the CAPSAC recommendations are amended merely to reflect the changed opportunities in training.

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Community nurses in child psychiatry

DEAR SIRS

The child psychiatrists in the Wessex Region have been considering the establishment of CPNs in the

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child psychiatric field (CCPNs) in every district of the Region. We felt this matter might be of more general interest. After a great deal of discussion, we felt that the training, therapeutic role and case load of CPNs and their line management were particularly important.

We found that, because there is no widely available specialist training for community nurses in child psychiatry, different areas had approached the problems in different ways. Some areas had instituted their own in-service training, while others required CCPNs to have post-graduate training, such as the Course 603. Many CCPNs had long experience working in child and adolescent in-patient units, but even so, find the change to community work quite threatening and isolating. Because of this, it was felt particularly important that the CCPNs should operate as members of a strongly supportive multidisciplinary team. It is vital that CCPNs learn about available local facilities, and other workers in the community, and are able to liaise and co-operate with them. We became aware that there could be openings for workers from other fields, such as occupational therapy or education, to work in the community, and some experimental posts in one district were advertised as "requiring relevant qualification and experience in child and family work".

It was generally felt that "relevant experience" required skills in dealing with relationship problems between mothers and children, including attachment and bonding difficulties, as well as an ability to use a variety of therapies, including family therapy, behaviour therapy, social skills and group work. It is important that the case load remains small, say ten to twelve families, reflecting the expectation that community nurses will work intensively, and at times, use flexible hours.

Line management presented no problems with posts developed in an in-patient setting, but was more problematical in relation to a child guidance clinic, where we found discussion with local directors of nursing proved helpful. We felt it important to draw a well defined boundary between CPNs in adult psychiatry, and those in the child psychiatric field. We have sample job descriptions which might be helpful.

One issue that gave rise to a great deal of heated discussion was the question of autonomy. It is always important for CPNs to operate as part of a multidisciplinary team. At the same time, it seems clear that there is a move towards more professional independence on the part of nurses, with postgraduate specialisation and qualification. Where a particular nurse has wide experience and training, the team may not feel too threatened by the CCPNs having a good deal of autonomy, and even accepting direct referrals. At the present time, most clinics will continue to function with the child psychiatrist supervising, and accepting clinical responsibility for the CCPN's work.

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Community based programmes for mental illness

DEAR SIRS

I have followed the discussions about the moves to community care with great interest; many of the arguments for and against have now been aired. These arguments revolve around the best arrangements for the care of the chronically ill patients with respect to their current needs. However, there are some areas which I feel have not been discussed adequately and, although they do not affect the immediate care of patients, they nevertheless have long-term consequences.

Firstly, I do not think that the manpower implications of the moves to community care have been fully thought through. Clearly, a psychiatrist covering several small units in the community is going to spend much more time travelling and much more time liaising with different teams than in a centralised service. Unless he or she is very careful there may also be far less contact with trainee psychiatrists than in the base hospital, and certainly there will be very much less time to 'rub shoulders' with colleagues and for discussion of day to day matters of interest or importance. Educational activities such as clinical meetings and journal clubs may also suffer. Even if these are organised, those senior and junior psychiatrists working in the community may have difficulty getting to them. Although these activities do not affect patient care short-term, they clearly have long-term implications for training and standards of care.

Secondly, while I acknowledge that much research is still needed into the social aetiologies and consequences of psychiatric disorders and that arguably this is best conducted from a community base, the biological aspects of psychiatric disorders may not be. The new investigative and imaging techniques which are being developed (for example NMR) are going to provide tools for the understanding of brain structure and function in a way which has not previously been possible. It seems ironic that, just at a time when these powerful tools are being developed, there is a danger that psychiatrists will move away from their medical and biological base and sequester themselves in the 'community'. Research into psychiatic disorder, I believe, should be an active process conducted at least in part by clinicians who are familiar with the problems of definition and classifi-