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Is there a case for 'unidisciplinary working' in child psychiatry?

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In many parts of the country, child psychiatrists currently provide services on their own. This 'unidisciplinary' model of practice is out of step with College recommendations for multidisciplinary working in child and adolescent psychiatry (Royal College of Psychiatrists, 1990). The question arises whether one model is in fact superior to the other. In this article we look briefly at the history of the multidisciplinary team, describe our own experience of providing a unidisciplinary service and suggest a working model for the future.

History of the multidisciplinary team working

Since the 1920s child psychiatry has evolved as a pluralist speciality with psychiatrists seldom providing services on their own. Although multidisciplinary work contributed substantially to advances in treatment, the model has not, however, been without disadvantage, especially in terms of problems in organisational relationships and the restrictions placed on the separate development of component disciplines (Parry-Jones, 1990). Other difficulties associated with multidisciplinary working that have been identified include inter-disciplinary rivalry, salary differences, conflicts over status and power, personality clashes, differences in sources of funding leading to policy and procedural problems, and finally, ownership of the premises where the team is based can become the focus for inter-agency friction (Trowell, 1990).

Our experience of providing a unidisciplinary service

This was an interim service in operation for two and a half years for the children and families of Coventry. It started after the dismantling of the old multidisciplinary team which was based on the child guidance model of operating out of education premises, and lasted until the setting up of a new multi-skills team along recommended College guidelines and operating out of hospital premises. The catalyst for these changes was the withdrawal of experienced, senior social workers from the child guidance centre in 1988, an occurrence which was mirrored or threatened in child guidance clinics and hospital bases of child psychiatry up and down the country at that time.

The first task of the new service was to inform potential referring agencies of its existence, to define access to the referral system, to re-define suitability of referrals, and to indicate how cases would be dealt with by way of assessment and treatment. It became clear very quickly that it was possible to offer a faster and more efficient service in terms of appointments being given within two to four weeks of receipt of a referral eliminating the need for a waiting list, and leading to lower attrition and re-referral rates, all of which are factors known to be important in improving general practitioner satisfaction (Bailey, 1989).

It was possible to fulfil effectively the responsibilities of consultant child and adolescent psychiatrists outlined in the College working party report in terms of the clinical, administrative and teaching responsibilities, continuing education and research and development of the speciality (Royal College of Psychiatrists, 1986). The service offered, where appropriate, liaison, consultation or joint work with social services, the NSPCC, the educational psychologist service, paediatricians and others.

At a political administrative level, the child psychiatry service became affiliated with the mental health unit, both of which became part of the wider community care unit. The district health authority was then persuaded through the offices of the unit chief executive to allocate for the first time an actual budget for child psychiatry with monies for the recruitment of a multi-skills team to the speciality. This expansion in the service was to include senior grade posts in clinical psychology, occupational

therapy, social work and community psychiatric nursing.

A working model for the future

The circle is now complete and we are able to draw some conclusions.

It is clear to us that the unidisciplinary model is a positive and viable option and is certainly preferable to working in a situation of multidisciplinary 'angst' or 'breakdown'. It is also likely in many districts to be the only option where, for example, allied disciplines, such as clinical psychology or community psychiatric nursing decide to set up services in parallel claiming reduced financial cost. Where the unidisciplinary model may, however, fail is in the area of primary prevention and health promotion which is understandable in terms of the resources and personnel required for this kind of activity.

Child psychiatry, on the other hand, remains a pluralist area that benefits from the active input of its component disciplines. It is, in effect, a corporate specialty whose future lies in developing a corporate identity such as would be possible in a clinical directorate with an independent budget holding facility. Accountability would be to district management in terms of agreed targets of clinical activity and across districts through an auditing process with other child psychiatric services.

The child psychiatrist would be assumed to provide professional leadership and to undertake managerial responsibility for the service. Within this model, analysis of the tasks of assessment and treatment will reflect professional and financial reality and will, through the key process of accountability, minimise some of the difficulties previously associated with multidisciplinary working.

In this way there will be recognition of the 'multiskills' concept that specific therapeutic expertise does not necessarily belong to specific professions but can, and does, exist across disciplines (Royal College of Psychiatrists, 1990). There will also be recognition of the possible problems of line management of different disciplines in imposing expectations and obligations on their workers, creating obstacles to effective team work with feelings of ambivalence and opposing loyalties among team members (Fagin, 1985).

Finally, the philosophical orientation of the service will be towards primary preventive and health promotion measures, utilising resources and personnel to achieve specified targets agreed between consumer, provider and 'customer'.

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American Psychiatric Association

Area VII of the American Psychiatric Association is organising a three day continuing medical education meeting on the Hawaiian island of Maui from 26–28 March 1992. If any member of the College is attending this meeting, please contact The Secretary, Royal College of Psychiatrists.