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Future directions for research in child and adolescent psychiatry*

Research Committee of the Royal College of Psychiatrists

Aim of the seminar

The identification of research priorities in child and adolescent psychiatry with a focus on areas of relevance to the Royal College of Psychiatrists Research Unit, in particular audit.

Format

The one day seminar was built around three invited presentations which provided a basis for discussion that was extended into a final open session.

(1) The Prevention of Child Psychiatric Disorders: Professor I. Kolvin.
(2) Developing and Evaluating a Model District Service for Child and Adolescent Psychiatry: Drs S. Wolkind and F. Subotsky.
(3) Audit in Child and Adolescent Psychiatry: Professor R. Nicol.

The programme was introduced and chaired by Professor M. Gelder, Chairman of the Research Committee. It was prefaced by an account of the structure, aims and function of the Research Unit by Professor J. Wing, Director of the Unit.

Others attending were Dr D. Brooksbank, Department of Health, Dr A. Gath, Registrar of the College, and senior academics in child and adolescent psychiatry in the United Kingdom: Professors P. Graham, D. Taylor, and W. Parry-Jones and Dr E. Taylor. Professor A. Cox organised the seminar.

Introduction

Emphasis was placed on:

(i) research that might be carried out by the College and/or supported by the Research Unit
(ii) the contribution of service research to audit
(iii) the value of research methods and findings for the organisation of medical audit.

The College Research Unit

The Research Unit has full funding from the Membership of the College for three years.

Audit has emerged as a central issue for the Research Unit. The term clinical audit may be preferred to medical audit because it takes into account the diversity of a psychiatrist's activities, many of which are in collaboration with other professional groups.

Five areas are of special interest to the Research Unit at the present time:

(i) the discharge of acute patients into the community
(ii) long-term residential care including residential facilities for those who are technically homeless
(iii) psychiatric aspects of mental handicap
(iv) suicide
(v) old age.

Discussion emphasised:

(a) the developmental perspective: continuities between childhood and adult life, and earlier precursors of adult mental illness
(b) the family as an important context for psychiatric patients
(c) the accumulation of new young chronic patients.

Prevention

Theoretically, prevention is best focused at the 'early secondary' level, but this requires effective and expeditious screening, and raises questions.

(i) Can high risk (vulnerable) populations be engaged effectively?
(ii) How can the effects of cumulative social disadvantages be combatted?
(iii) How can the interventions be justified and assessed if the risk of later disorder is reduced but not removed?
(iv) Is it appropriate to apply cost/benefit analysis to interventions with the children?

The Headstart and Newcastle projects point to the feasibility and effectiveness of early secondary preventive intervention and suggest the following:

(i) There may be a long lag before the benefits of prevention appear. Can children wait?
(ii) Long-term follow-up is necessary for adequate evaluation.

Seminar held on 21 February 1990.

(iii) It is necessary to show that treatment is effective despite family and environmental factors that influence outcome.
(iv) Multiple indicators of change are required because there may be improvements or deteriorations in unanticipated areas.
(v) Multiple social and family factors need to be assessed because they may mitigate the effects of deprivation, and some such as maternal resilience may overshadow the impact of the intervention.

Issues arising from discussion

(a) How should services be targeted?
  (i) On rare disorders requiring highly skilled assessment or common disorders susceptible to primary health care interventions, or both?
  (ii) On the amelioration of important social factors or only on their identification – leaving intervention to the state?
  (iii) On child dysfunction or family dysfunction?
  (iv) On the general population or on high risk populations or only those children who have psychological or psychiatric disorders?
  (v) On those who are going to respond to intervention or all those with high risk?
(b) How should the effectiveness of intervention be assessed?
  (i) By looking for adverse effects of intervention as well as benefits?
  (ii) By categorical and/or dimensional assessments of child dysfunction?
  (iii) By improvements in a child's 'life' or the attainment of the goals of the intervention?
  (iv) By whether the intervention is replicable?
(c) How should services be organised?
  (i) By training in primary health care?
  (ii) By working with paediatrics?
  (iii) By working with education?
(d) Can the identification of childhood psychological and psychiatric dysfunction be improved? e.g. how early can child autism be identified?
(e) Important high risk groups mentioned included children
  (i) of parents with major affective or schizophrenic disorders
  (ii) those with epilepsy
  (iii) those who have been in care
  (iv) those from families with cumulative disadvantage
  (v) those with mental retardation and/or language delay.

It was concluded that effective methods for distributing current knowledge are needed and that a review should be published about current knowledge of relevant social factors.

Developing and evaluating a model district service for child and adolescent psychiatry

(i) There has been little progress in service research in child psychiatry.
(ii) There are very large numbers of children with psychiatric disorders.
(iii) Many of these disorders indicate a poor prognosis for a child's future psycho-social functioning.
(iv) There are treatments which are effective for some of these disorders.
(v) Resources are scarce. How can they be used for the best?
(vi) In any one district services may be available from a range of agencies with conflicting notions of intervention.
(vii) The services are available in an uncoordinated manner with many very vulnerable children slipping through the net and others receiving duplicated and wasteful interventions from several workers.

In considering service development it is important to distinguish need, demand, and provision.

It was suggested that a major priority is to undertake a 'bottom up' assessment of need in a given community to see what proportion of that need was being met and whether the help offered was the most appropriate in the light of research knowledge. For example, child psychiatrists are advised to spend up to 30% of their clinical time consulting with primary care workers rather than seeing children and their families directly. The recommended study could examine if and how such consultative work impinges on the sample children themselves.

(i) Methodology for assessing need would be established to measure how changes in the delivery of services affect the impact of those services on the community.
(ii) The 'community' for the study would be the population of a large group general practice.
(iii) Studies of impairment and perceived need would be made and the pathways to treatment noted.

With the possibilities of major changes occurring in the NHS it is essential that child psychiatry is able to demonstrate its worth to managers and general practices so that it is supported and used.

Discussion raised the following issues

(a) It was thought essential to define minimal service provision but there was general support for a 'bottom up' approach in establishing appropriate provision.
(b) It was suggested that professionals should establish the criteria for need on the basis of what the professional services intend to address.

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(c) It was acknowledged that districts differ widely in need.
(d) There are also wide differences in demand. For example, some general practitioners never refer to child mental health services, but there are also many complaints reaching the Department of Health that services do not meet need.
(e) Provision of a service tends to increase demand which is also influenced by education of professionals and the general public
(f) Provision: It is important to clarify and establish the most fitting relationship between child psychiatrists and child mental health services. If child psychiatrists lead a team of less expensive professionals this might lead to a reasonably priced service but if child psychiatrists are not linked to other professionals in this way there may be a problem.
(g) Provision: It was suggested that it is possible to define which children should be seen by child psychiatrists, for example all those with pervasive developmental disorders and severe emotional and conduct disorders. Research indicates that children referred to child psychiatrists have more severe disorders than the majority of those reaching general practitioners.
(h) The development of appropriate methodology cannot be underestimated in such service research because it is crucial that the different professionals and professional groups are asking the same questions about what they are doing.

Audit in child and adolescent psychiatry

(i) Terminology was reviewed (see The Royal College of Psychiatrists: Preliminary Report on Medical Audit *Psychiatric Bulletin* (1989) **13,** 577–580).
(ii) Audit is concerned with the evaluation of resources, process and outcome. There are many unresolved questions about both the measures and methods that are most appropriate to assess the three different aspects. For example:
  (a) There is a need to assess quality as well as quantity of service provisions.
  (b) What are the advantages and disadvantages of evaluating a random selection of 'run of the mill' cases versus a review of the occurrence of undesirable events such as the deaths of children or child abuse?
  (c) How well do indicators such as 'waiting time' or 'drop-out from treatment' measure the level of resources, quality of process or outcome?
(iii) The importance of recording the full range of professional activities was emphasised, for example consultations.

Discussion covered

(a) The need to identify the questions concerning resources, process and outcome.
(b) The evaluation of indicators or measures of the different aspects of audit.
(c) The need to move towards quality assurance which provides guidelines about appropriate service response to specific problems, so that there are standards against which process can be assessed.
(d) The value of the effective costing of services.

Conclusions and recommendations

(1) It was recommended that the Child and Adolescent Section of the College should lay out any agreed basic minimum provision for a child mental health service.
(2) It was proposed that the Research Committee of the College should in conjunction with the Research Unit facilitate a pilot project exploring quality assurance for childhood autism.
(3) It was recommended that a letter be written to the Department of Health under the auspices of the Research Committee proposing research into (expensive) residential facilities for children and adolescents.

    The need for research into expensive patients including new young chronic patients was also identified.
(4) It was noted that a major priority is the identification of appropriate questions for auditing services. There is a current college working party on audit which also receives contributions from Child and Adolescent Psychiatry, but it was proposed that the Research Committee should establish a working group focussed on this issue. It is also an important part of the agenda for the College Research Unit.
(5) It was recorded that both 'top down' and 'bottom up' approaches to the definition of model services are required. The Research Unit is interested to share discussion with sections about 'top down' definitions of model services and facilitate 'bottom up' research.
(6) It was suggested that a review of current knowledge about social factors relevant to the genesis and maintenance of child psychiatric disorders is needed.

Approved by the Executive and Finance Committee December 1990