

One could thus see the views of child and adolescent psychiatrists as the most vital. It is therefore of great significance that they are the most satisfied, the most intending to refer, and the most perceptive of the need for in-patient adolescent beds. In short, they are aware of the limitations of their own district-based facilities for managing severe adolescent disorder.

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Usage of professional time: a case by case analysis

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The study

Child and adolescent psychiatric services receive referrals from a variety of sources in addition to traditional medical channels. It is unknown whether this practice has implications in patterns of usage of time. Our hypothesis was that referrals from non-medical sources were likely to be more time-consuming than those from medical colleagues.

Diagnostic related groups (DRGs) have been proposed for some specialities as being a possible way of simplifying the complex task of monitoring and quantifying resources needed for the management of disorders. Their usefulness in child and adolescent psychiatric services is currently doubtful and unproven (Parry-Jones, 1990). Our hypothesis was that narrower groups than those previously used may be helpful in predicting workload.

This paper was first presented as a short paper at the Annual Residential Meeting of the Child and Adolescent Psychiatry Section of The Royal College of Psychiatrists held in Glasgow in September 1990.

All new referrals received between 1 February 1990 and 31 May 1990 by a sub-regional (serving six health districts) in-patient adolescent unit were entered into the study. This unit also provides a supra-district out-patient and day patient service to young people aged between 13 and 19 years. The philosophy and style of working is multidisciplinary with an out-patient team consisting of two consultant psychiatrists, one senior registrar, one senior clerical medical officer (psychiatry), one principal psychologist and one senior social worker.

Following referral and allocation to a member of the team, all professional activity directly related to the case was timed and logged under one of six headings: direct contact with patient; direct contact with relatives; case management; administration; travel; lost. This was recorded on a front sheet attached to the notes to ensure greatest reliability. This recording was continued until 31 July 1990 (i.e. six months after inception of the study).

Also recorded for each referral were age and sex of young person, discipline of referrer, health district of origin and ICD-9 diagnoses (World Health

Organization, 1978). On completion of the study the number of direct patient interviews and their current involvement with the unit or discharge status were recorded. Independent check diagnoses from the information recorded in the case notes were made in 37 cases.

Findings

One hundred and forty-five new referrals were received by the unit in the four months study period generating 164 ICD-9 diagnoses. Diagnostic disagreement occurred in 3/37 check cases but this could be resolved by discussion in each case. Ages were normally distributed within the population served with 70% aged 14, 15 or 16 years. For analysis, diagnoses were combined into six broad groups: neurotic disorders 52 cases; conduct disorders 46 cases; acts of self-harm 32 cases; psychotic disorders 11 cases; eating disorders 8 cases; others 15 cases. At the close of the study (2–6 months after first appointment) 39% of patients had been discharged by agreement, 9% had become day patients, 6% in-patients and 17% were continuing in out-patient follow-up. Fifteen per cent had not responded to two initial appointment letters and a further 15% had initially attended but later failed two consecutive appointments and been discharged in absentia.

Total amount of time devoted to each referral ranged from 0 to 40 hours with a mean of 6 hours (standard deviation $4\frac{1}{2}$ hours) but only one-third of this was spent in direct patient contact. Analysis by referral discipline showed little difference between those referrals received from general practitioners (60 referrals) and from hospital doctors (40 referrals) but did reveal twice as much time spent in management on referrals from non-medical disciplines (mean times 60 minutes v. 30 minutes). Similarly, referrals from non-medical sources necessitated greater time spent in travel (mean times: GP 10 minutes; hospital 30 minutes; non-medical 50 minutes). The correlation between total time used per case and the number of interviews with the patient also was poorer for the non-medical group ($r=0.79$ compared with $r=0.84$ for medically derived referrals). Break-down by diagnostic grouping showed little differences in time but with a tendency to suggest greater continuing involvement with those with eating disorders.

Comment

These results reflect the clinical practice of one unit and therefore may not be typical of all child and adolescent psychiatric services although the diag-

nostic case mix is a broad one. Nonetheless there are some points that do seem of general relevance.

The most important finding was that for each hour spent with a patient two hours of time were spent on activities directly related to that patient. It is well recognised that much of the clinician's workload is not in direct patient contact (Nicol, 1989). This study differs from previous work in its monitoring of referral-related time rather than the clinician's daily activities but still demonstrates that approximately two-thirds of the professional time allocated to any referral is spent away from direct patient contact. While in normal clinical practice this 'off the ball' activity is difficult to quantify because the total time correlates well with the absolute number of direct patient interviews, nonetheless predictive adjustment can be made.

The weakness of any relationship between diagnostic grouping and consumption of time was surprising and in particular the lack of any distinction between the groups with neurotic or conduct disturbance. The tendency for those with eating disorders to be seen more times and for longer and for those referred following acts of self-harm to be seen less could perhaps have been predicted. These findings may point the way towards a useful sub-group of DRG-like categories for child and adolescent psychiatry while confirming their lack of general applicability to the speciality.

These findings do show a modest quantitative difference in time usage between referrals from medical and non-medical disciplines. This difference is most marked in the amount of time spent in management and to a lesser extent travel. This presumably reflects both the need for meetings and case conferences, often away from a hospital base, and the issues that can arise from different professional agendas. It is further important to note that the total time spent is less closely related to the number of direct patient contacts. With the increasing emphasis on community care and preventive interventions, this finding potentially has major implications for staffing and resource needs.

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