Child and adolescent mental health services: purchasers' knowledge and plans

Michel Vanstraelen, David Cottrell

All purchasers in the North East Thames Regional Health Authority were contacted by telephone and questioned systematically about their purchasing plans for child and adolescent mental health. Purchasers' knowledge of the services they were purchasing was very limited. They had made little or no attempt to set quality standards or to monitor them. It is concluded that information about these services is so limited that purchasers would be unable to make informed decisions concerning changes in service patterns.

The scale of psychological problems in children in the community is often not realised. Depending on prevailing levels of socioeconomic deprivation, between 7% and 20% of children and teenagers will have a child psychiatric disorder,[1] and although some of these are relatively mild, development or functioning, or both, will be significantly impaired in 5-10%. The table shows the numbers of children with disorders in a typical district of 300 000 people, where about a quarter of the population will be aged up to 18 years. Such figures are intended only as a rough guide. When there is considerable comorbidity these figures will be inflated; presenting data for only a few common conditions and only at certain age ranges (no figures are presented for children under 4 years with emotional and behavioural difficulties) will distort in the opposite direction.

Prevalence of child psychiatric disorder in a population of 75 000 children and adolescents (up to the age of 18 years)

Diagnosis	Age (years)	No affected (n=15 795)
Conduct disorder	4-11	2740
	12-16	2940
Attention deficit disorder with hyperactivity (DSM-III)	4-16	3240
Substance abuse	16	720
Emotional disorder	4-16	5400
Enuresis	10	110
Encopresis	10-11	65
Anorexia nervosa (DSM-III)	14-17	50
Bulimia nervosa (DSM-III)	14-17	410
Autism or autism spectrum	2-15	120

Calculations assume even age distribution across years and no comorbidity. Prevalences taken from Wieselberg.[1]

Only about 10% of children in the community with disorders are in contact with helping agencies at any one time.[2] This would matter less if these were the most severely disturbed children, but there is evidence that this is not the case, suggesting that large numbers of children with psychiatric disorder are slipping through the net. Tower Hamlets, a very deprived inner city district in the region, has a child population (up to 18 years) of 45 000-50 000. Assuming a high prevalence of 20% because of the high levels of deprivation leads to a prediction of 9000-10 000 children with pronounced disorder. If 10% of these young people were to be referred, 900-1000 new referrals a year would be expected. In 1992-3 the child mental health service in Tower Hamlets received 940 new referrals.

In clinical populations, prevalence can be even higher. Behaviour problems have been cited as the third commonest reason for children being taken to see their general practitioner.[3] Screening of all children attending general practice suggests that 25% may have a psychiatric disorder.[4] Different disorders present at different times in the child's life: sleeping, feeding, behavioural problems, and developmental concerns are predominant in the preschool years. Difficulties with school and social functioning emerge as the child gets older; depression and deliberate self harm, psychosis, and eating disorders are unlikely to present before adolescence. Emotional and behavioural problems linked to the effects of child abuse can present at any time. Referrals where child abuse is either suspected or confirmed have constituted about a quarter of all referrals in Tower Hamlets in the past two years.

Referrals to child mental health services have been increasing steadily in the past few years for reasons which have been well documented elsewhere.[5] This has put further strain on already stretched resources and made the need for properly planned and coordinated services even more urgent. Identification and onward referral of many of these conditions are important as many of them are treatable. If they are left untreated, there is increasing evidence that some conditions (childhood anxiety, obsessional disorders, aggressive behaviours) may continue into adult life.[6] Untreated children with, for example, conduct disorder may require years of expensive special education; their families will need social work support; they will be at greater risk of criminal conviction and unemployment and may cost the state many thousands of pounds over their lifetimes. Light and Bailey have recently highlighted the relative effectiveness of child mental health services and in particular the possibilities for purchasing for health gain.[7] They make the point that a referral to child mental health services will often cost less than existing support services, as well as offering the possibility of successful treatment rather than just containment of the problem. It is worth noting that two of the Health of the Nation targets, reduction in suicide in young people and reduction in teenage pregnancies, are likely to be influenced directly by well functioning child mental health services.

Unfortunately, a lack of appreciation by district health authorities in the past of the mental health needs of children in the population means that many services around the country are underdeveloped. This is just the kind of situation which, the government has argued, would be remedied by the NHS reforms. A clearly defined but unmet local need could be addressed by local purchasers in their contracting with providers. Because the reforms are still relatively recent, there is little information available about the purchasing plans of different health authorities. We therefore decided to survey all the purchasers in the North East Thames regional health authority concerning their purchasing plans for child mental health services. As far as we are aware this is the first review of its kind.

Method

We obtained a list of all the purchasing authorities in the regional health authority and contacted their

Department of Psychiatry, London Hospital Medical College, London E1 2AD
Michel Vanstraelen, *registrar in psychiatry*
David Cottrell, *senior lecturer in child and adolescent psychiatry*

Correspondence to:
Professor David Cottrell, Academic Unit of Child and Adolescent Mental Health, 12A Clarendon Road, Leeds LS2 9NN.

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contracts department by telephone. Using a predetermined, semistructured format we asked each purchaser if they had a specific contract for child mental health. We asked for detailed information in four key areas:

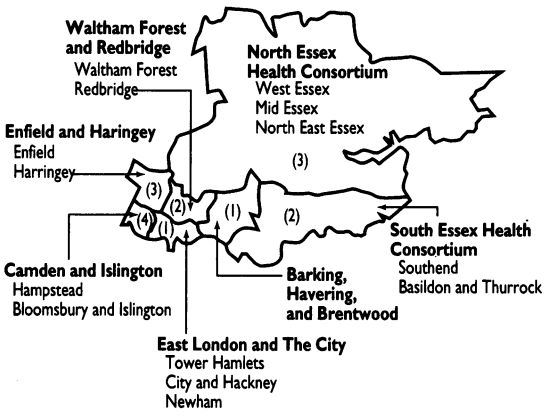
the exact service specified, with activity levels;
the budget allocated for the service;
any quality standards set; and
the mechanisms for monitoring quality standards.

In addition to telephone interviews we asked for copies of all relevant documentation.

Results

The results presented here are, to the best of our knowledge, correct as of December 1993. We are aware that many providers may be offering services in excess of what we describe, and many purchasers may claim that they know more about services than we have indicated. This paper reports only what could be ascertained about services from purchasing authorities.

To our surprise it proved quite difficult to obtain a clear picture of who the purchasers and providers were in the region. Before 1989 there were 16 discrete districts; since then a number of mergers of purchasing authorities have taken place so that there are now just seven purchasers. Providers, on the other hand, have proliferated and now number 37, including the Essex Ambulance Service. The figure shows the new purchasing authorities and the old districts which they now incorporate. The number of units providing child mental health services in each area is also indicated.



New purchasing authorities (bold type) and old districts in North East Thames region, December 1993. Numbers in brackets are number of provider units

At the time of writing, the community providers in the three districts that are now the East London and The City Health Authority were being merged into one new provider unit, as recommended by the Tomlinson report. Purchasing plans at the time of this study were still based around the three old districts.

In most areas the number of providers reflects the number of previously existing district services. Most competition exists in the new Camden and Islington Health Authority, where there are four provider units. Only in Haringey, where both the acute and community trusts provide some child mental health service, has competition increased as a result of new organisations providing a service. In East London the planned merger of the community services from three districts into one provider unit will decrease competition.

Whereas purchasers have tended to retain names which reflect their constituent health authorities and geographical location, providers have been more creative about nomenclature, leading to occasional difficulties in knowing where providers are based and what kind of service they are providing. Where, for example, might the New Possibilities NHS Trust, Essex Rivers Healthcare NHS Trust, or Thameside Community Healthcare NHS Trust be expected to be found? Collecting information about who these new organisations were, and how to contact them, took some time.

Our second problem was finding someone in the purchasing authority who had sufficient knowledge about child mental health services. Management structures and hierarchies differed substantially across health authorities. Within the provider units some child mental health services were managed within mental health units and some within paediatric units, and one was managed as a "stand alone" clinical directorate. In one authority different parts of the service were managed within different units. One or two purchasers asked us to contact their local provider to clarify what service they were buying—and then to let them know. Some purchasers were able to furnish us with detailed descriptions of the service they bought in the form of annual reports prepared by the local provider service (for example, Waltham Forest Child and Family Consultation Service, Mid Essex Child and Family Guidance Service). However, these did not contain financial information or any quality standards.

Only in Tower Hamlets was there a comprehensive service specification with a reference to contract volume and a clear budget allocation. City and Hackney mentioned child mental health within the specification for child health but only for a few lines. Similarly, Barking, Havering, and Brentwood devoted just a few lines to child mental health in its adult mental health specification. North Essex had very little information but was aware of this and had instituted a major review of services. Only Tower Hamlets could provide clear information concerning the cost of the service being purchased.

The setting and monitoring of quality standards was largely ignored. In Tower Hamlets, detailed information (referral source, ethnic origin, and geographical area) was asked of providers concerning the number of cases seen. Quality standards concerned only waiting time between referral and first appointment. South Essex providers had suggested their own standards to their purchaser, which seemed to have been accepted. These related to waiting times for appointments and individual care plans. City and Hackney and Newham also required waiting times but nothing else. Barking, Havering, and Brentwood requested only basic Körner information but had indicated to its provider that it expected the provider to produce quality guidelines of its own for further discussion.

Camden and Islington could tell us nothing whatsoever about its local service, and Enfield and Haringey could only tell us how many consultants' salaries it paid. (The authors' knowledge of local services suggests that the figure supplied was inaccurate.) The only information that Waltham Forest and Redbridge was able to supply was a detailed annual report describing the Waltham Forest part of the service; this had been provided for it, unasked, by the provider unit.

In the course of our inquiries we discovered from colleagues in provider units that the survival of many of their services was threatened by withdrawal of funding from education and social service departments. Child mental health services have traditionally been funded by a combination of health, education and social services. Essex education department is currently considering withdrawal of its support; Tower Hamlets education department has already done this. Waltham Forest social services have made severe cuts in funding to child mental health, and similar cuts are threatened around the region. None of the purchasers expressed

any awareness of or concern about these changes.

A further concern among service providers in the region has been the threat to inpatient treatment units. Only three of these exist within the region and probably no more are required. These units are now threatened by the purchasers' difficulties in formulating a mechanism for ensuring their continuation.

Discussion

The effectiveness of the NHS reforms in bringing about a more cost effective health service depends on successful contracting between purchaser and provider. The Department of Health wants clinicians to be more involved in the contracting process and contracts to be more sophisticated than at present. Our evidence suggests that in the area of child mental health the system is not, as yet, working at all. Data about current levels of activity and the costs of this activity were woefully inadequate in many areas. Collecting accurate patient activity and financial information on which to base the contracting process has been made more difficult by the short term organisational upheaval caused by mergers of purchasing authorities and splits of provider units. With current levels of information a more sophisticated contracting process is unlikely to develop in the near future. Similarly, if new providers were to enter the market now it seems most unlikely that purchasers would be well enough informed to make judgments about whether or not to purchase these new services.

It is to be hoped that, with time, services will be more clearly specified. Even where specifications exist, however, the dearth of meaningful quality standards is worrying. The Patient's Charter emphasises the need for continuity of care, with patients seeing the same doctor at each outpatient visit, and the provision of individual appointment times. Child psychiatrists have been doing this routinely for years, and astute providers have earned some credit by offering to meet these standards.

We must, as a profession, think more seriously about the elements of a quality child mental health service. Although some guidance has already been produced,[8,9] attempts at defining quality standards in this survey were limited to issues concerning service delivery, such as waiting times, and did not deal with health outcomes. Measurement of health outcomes is difficult in child and adolescent mental health, although attempts have been made.[9]

Even if service delivery standards alone are to be addressed, there are more relevant standards than waiting time. Quality standards should address accessibility of services and focus on children's needs: is furniture appropriate to the smaller size of children? is there access for pushchairs and somewhere safe to leave them? are there baby changing facilities?

Purchasers should specify services that are genuinely multidisciplinary and include all of the core disciplines of medicine, psychology, nursing, social work, and child psychotherapy. Such services could also be required to provide a full range of treatment options, including day patient and inpatient facilities as well as a variety of outpatient psychological treatments. Liaison with other relevant professionals involved in child care—paediatricians, obstetricians, general practitioners, health visitors, schools, social services, etc—should also be specified. Finally, in specialties where many new academic centres have been established and where more and more outcome research is being carried out, purchasers might wish to require that services are provided by staff who have participated in planned programmes of continuing medical education.

Conclusion

North East Thames Regional Health Authority has had one of the highest vacancy rates for consultant child psychiatrists in the country[5] and could in theory benefit from local purchasers contracting for the services that are needed, particularly if joint purchasing arrangements could be made with the local authority. However, the necessary information to bring about effective purchasing is not available. Although the health service was, presumably, focusing on other areas, local education and social services in the region were withdrawing funding and putting at risk the future of what few services there are.

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A MEMORABLE PATIENT

Look at the stools!

In 1966, when I was the casualty duty medical officer at Medical College Hospital, Trivandrum, India, a 45 year old man arrived in a delirious state with severe abdominal pain and a history of rectal bleeding of three months' duration. He was afebrile but deeply jaundiced with a diffusely enlarged hard tender liver. He had a soft, friable, bleeding mass in the rectum, which I thought was a carcinoma of the rectum with secondaries in the liver. The surgeon agreed with my diagnosis, and a biopsy was arranged.

On my chief's ward round the next morning I presented the case with great pride. He just asked me whether the patient's stool was examined for amoeba. I said "no" with a little diffidence, since I could not understand the rationale of stool examination in such a straightforward case of carcinoma of the rectum. Within 10 minutes the resident who was asked to perform the stool examination called me to the laboratory to have a look through the microscope. To my surprise, the whole field was occupied by mobile *Entamoeba histolytica*. My chief was nonplussed, but told me to do a liver aspiration and biopsy. I still thought that my diagnosis was correct and that amoebic infection was just a coincidence. When I poked the aspiration needle into the liver typical anchovy sauce pus spurted out as if from a fountain, and about 600 ml of pus was aspirated. That was a classic case of amoeboma of the rectum with amoebic liver abscess. After a 10 day course of emetine hydrochloride the patient's jaundice cleared, bleeding stopped, amoebae vanished, and he walked back most happily. He would have died from my liberal dose of morphine or the rupture of a liver abscess had not a simple stool examination been done. My pride disappeared then and there, and I realised how right Sir William Osler was that "there is never a never in medicine."—K P PAULOSE *is a retired professor of medicine in India*