surviving into school life.¹⁶ Half of these survivors are grossly disabled, incontinent of urine, and walking with great difficulty or not able to walk at all. Medicine in making some sort of life possible for these unfortunate children has presented their families and the society in which they live with the sometimes intractable problem of making that life tolerable.

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Emotional Problems of Childhood and Adolescence

How to Use Child Psychiatry*

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To guide and advise the family doctor in his use of child psychiatry services, of community resources for children and young people, or in his decision whether to refer a child or adolescent for inpatient psychiatric treatment, is a task hampered by the lack of universally agreed criteria. This lack of agreement reflects several factors which affect the organization, policy, and practice of present psychiatric services for children and adolescents. In Scotland most consultants in this specialty work on a full-time basis in the National Health Service; to a greater or lesser degree provide the psychiatric services to this age group in a defined area; and have no formal appointments to local education authority child guidance clinics. In England and Wales, on the other hand, many psychiatrists work in child guidance clinics and many have sessional appointments in two or more agencies. Some child psychiatrists are based on paediatric, others on psychiatric, hospitals, and appointments to mental subnormality hospitals are being developed. Some child psychiatry services accept only those patients referred by medical colleagues, others also from non-medical agencies.

Services are uneven in distribution throughout the country and vary in staffing resources, facilities available, policy about the type of children and adolescents accepted for assessment and treatment, and in the range of treatments offered. It is rare for a department of child psychiatry to be responsible for the psychiatric services for the age group up to the age of 18 years or for any one department to have inpatient facilities for this whole age group. There is also a shortage of places in children's homes, residential schools for the handicapped and mal-

adjusted, hostels, approved schools, and borstals. In all of these are found young people of the type regularly referred to psychiatric services for children and adolescents and many psychiatrists have commitments to such institutions.

The child psychiatrist sees his patients only at the request of another professional colleague, his authority for assessing or treating a child being given him by this request and, he hopes, by child and parents. Clearly, just as referral is often still only a "last resort" so the necessary authority is often given reluctantly, without expectation of "success" even by the referring family doctor. While the psychiatrist must define for himself the nature and limits of his professional responsibility, he has an accountability to patients and their parents and also to colleagues. Some family doctors expect the child psychiatry service to undertake the whole responsibility of seeing child and family through a process of assessment and treatment, even if this involves non-medical agencies and do not expect to be regularly informed of progress or lack of it. Others expect to be kept informed of progress, though not all consider that they should keep the psychiatrist informed. Some family doctors expect advice on what they might do in exercising their responsibility for primary care; others resent such advice. These attitudes, and frequent comments from psychiatrists and family doctors about lack of adequate communication, express different and not easily reconcilable views of both child psychiatry and general practice. It would be helpful to both if the professionals concerned were to consider this a serious issue worth discussing, in order to reach some measure of agreement in each local situation.

Non-psychiatric Services

Child psychiatry services represent only one of the many services, agencies, and organizations responsible for providing help to children, adolescents, and parents in need and see only a minority of the young people who might be referred to them. The family doctor has a choice: to refer a child to a non-psychiatric service, as a decision of preference, or as a step towards referral to a psychiatric service. He has both a responsibility to know something of the non-psychiatric services in his

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area and a right to call on them for help. From the local authority services he may seek material help—for example, finance and housing for a deprived family whose children's personality development is threatened by adverse environmental factors. A home help may be necessary for the young mother overburdened with more young children than she can adequately mother: a "battered baby" situation may be prevented if the doctor does not minimize a mother's mounting intolerance of her children or her fear that she may harm the baby. And he may consider that the best way of helping such families is to help parents take advice on, and use, contraceptive measures.

The school medical service can advise on a child's readiness or fitness for school. This service, the education authority, or a voluntary agency can arrange for a child to benefit from attendance at nursery school (of which there are still too few) or preschool play group (of which, fortunately, there is an increasing number). Local authority social services are responsible for providing temporary or permanent care in foster-homes or children's homes for those young people whose parents are for some reason unable or unfit to care for them. Social work departments in Scotland and probation departments in England and Wales are concerned with the child or adolescent whose pattern of behaviour is delinquent. The help of the local education authority is required if some form of special education, day or residential, is thought appropriate.

In many areas the youth and community services of the local education authority are more able to respond to the needs of adolescents in difficulties with themselves, their peers, or society than are the psychiatric services. And it may also be the case that non-psychiatric and non-statutory services may be able to do more for the young person becoming dependent on, or abusing, drugs than the treatment programmes of psychiatry. Many children who present with physical symptoms have no demonstrable organic illness and some of them may respond to psychiatric treatment, but the family doctor may consider that all such young people should be referred first to a paediatrician or general physician. While some enuretic children may respond to psychiatric treatment, many need adequate physical assessment, not least girls wetting by day, while encopretic children should always be assessed physically before psychiatric treatment is considered. It is important for family doctors, their young patients and parents, that such choices are available, not only so that the right of choice is retained but also as a realistic appreciation of the value of such services and of the limitations of psychiatric services, which cannot offer panaceas to all the ills to which children and families are subject.

Psychiatric Services for Children and Adolescents

The psychiatrist who works with children, adolescents and their parents is by training and experience interested in young people who are ill, suffering from specific diseases or disorders. But he is also concerned with disorders of function which, often multifactorial in aetiology, present in several aspects of the young person's behaviour, relationships, feelings, and performance. He is concerned with deviation from the normal of the child's behaviour pattern and of his developmental progress.¹ He is interested in the young person as an individual, as a member of a family, of a wider peer group and of society. Equally important is his concern with development, with both child and family attaining the potential of which they are capable and of leading emotionally satisfying lives. Whether by pharmacotherapy or psychotherapy, the child psychiatrist may be able to help the child, his parents, or the family. He works closely with other professional colleagues, such as social workers and psychologists, and with other agencies concerned with the care, welfare, education, and treatment of young people. He does so because his potential patients may express their disorder in a variety of life situations and because neither he alone, nor he and his immediate colleagues, have readily avail-

able to them under their charge the full range of skills and facilities required by many of the young people referred.

When should the family doctor make use of the child psychiatry services? Rather than ask for an outpatient appointment for a patient he may prefer first to discuss the problem with the psychiatrist. While there is a limit to what can be achieved by a telephone conversation, this might be enough to encourage the family doctor to continue the treatment he has already initiated. More effective would be joint consultation in the patient's home, family doctor's surgery, or health centre. If these methods were used more often they might encourage the family doctor to undertake more child psychiatric work in his own practice, reduce the need to refer young people to the clinic, and act as a mutually educative process for both psychiatrist and family doctor.

TYPES OF PROBLEM

For what kinds of problem should the family doctor seek the advice of the child psychiatry services? Though there are differences in policy and practice, in my opinion, there are some young people who should be referred as a first choice to such a service if the family doctor considers that he himself cannot or should not treat such a child or adolescent. These conditions include the following:

(1) Disorders Related to Separation from Parent(s)

Under this heading, one would think of:

- (a) the child who, following his own or mother's prolonged period in hospital, is unable to relate to mother in a mutually satisfying way,
- (b) the child or adolescent who, about four months after the loss of a parent by death, separation, or divorce, appears still emotionally disabled in one way or another,
- (c) the child entering infant school, transferring from infant to primary or primary to secondary school, or a recent entrant to secondary school who, some months after a death in the family or the continued illness of an adult on whom dependent (remembering here the importance of grandparents and of pet animals), cannot leave home each morning for school; or who, being previously non-delinquent, develops a delinquent pattern of behaviour such as stealing or absconding from home.

(2) Depressive Illness in Child or Members of a Family

Examples of these include:

- (a) physical symptoms, overt anxiety, or acting out behaviour in the child or children of a mother who is depressed, especially the mother suffering from unresolved puerperal depression, which need not be clinically "severe" to have seriously adverse effects on the emotional health of her children,
- (b) the child or adolescent who appears depressed. Depressive disorders in children and adolescents are not rare and if not recognized early can be difficult to treat, with a poor prognosis in terms of the young person's capacity to function effectively,
- (c) talk of suicide, threats to commit suicide, or attempted suicide in children and adolescents. While not all such situations are indicative of depressive conditions, they should always be regarded seriously and never dismissed as gestures.

Other Conditions

Other conditions include the following:

- (a) The child thought to be autistic or the adolescent suspected of having a schizophrenic illness.
- (b) The abnormally anxious child or adolescent, however the anxiety is expressed.
- (c) The child or adolescent who shows obsessional, phobic, or apparently hysterical symptoms.
- (d) The child or adolescent who shows significant delays or deviations in psychosexual development or who remains anxious about such development after reassurance by the family doctor.

(e) The child or adolescent whose appetite or sleep rhythm are disordered without apparent cause.

(f) The adolescent in a state of confusion and panic, desperate in his desire to be away from parents and school, lost in his attempt to "find his own feet," including those who express such distress in aggressive or delinquent behaviour.

(g) The adolescent drug taker who seeks treatment or asks for help in giving up his use of drugs.

(h) The hyperkinetic, retarded, sometimes brain-damaged child, not responding to medication, whose tense, overactive, aggressive, destructive behaviour is so difficult to tolerate and control.

(i) The epileptic child or adolescent whose behaviour is aggressive, destructive, sometimes delinquent, whether or not seizures are difficult to control.

(j) The adolescent with anorexia nervosa, who may require emergency admission to a psychiatric unit.

(k) The obese child or adolescent, provided that he and parents are capable of undertaking both the psychological and dietary work involved.

(l) Children and adolescents suffering from asthma with a major psychogenic component, including severe cases not responding to pharmacotherapy, are in some areas agreed to be appropriate referrals.

(m) Some physically handicapped young people (the treatment of whose physical condition is properly the continuing responsibility of non-psychiatrists) who are so unable to accept, live with, or adapt to their handicap as to require psychiatric treatment in the hope of helping them to do so.

(n) Children and adolescents whose learning disabilities may have a significant emotional component and those who appear to be "under-achieving" at school because of unresolved emotional problems.

Indications for Inpatient Treatment

Psychiatric units for children and adolescents vary greatly in regard to the type of patient admitted and the range of treatment programmes offered. All of the conditions mentioned above, and others, may be seen at some time in such units. The criteria for admission tend to be the severity of the disorder, the complexity of the family psychopathology, and the lack of response to (or unavailability of) outpatient treatment, rather than admission according to particular diagnostic categories.

Child Psychiatry in General Practice

I know that most family doctors themselves attempt to help the majority of young people whose parents consult them, without

referral to a child psychiatry service, even when one is available within reasonable travelling distance. It needs to be emphasized that the family doctor who exercises what influence he can to ensure that children are well housed, well fed, and well clothed; who attends to immunization programmes; who deals successfully with the illnesses, sicknesses, and accidents of his young patients; who tries to ensure the continuing health of parents; who is available in times of crisis as supporter, counsellor, or the prescriber of appropriate medication; who helps families not to undertake burdens beyond their capacity—such a family doctor is making a positive contribution to the emotional health of children and adolescents. The family doctor who wishes to undertake his own child psychiatric work will need to spend time with individual children and adolescents, with their parents, with children and parents together, sometimes with whole families. He may have to see such individuals or groups regularly over a long period. He will have to tolerate the lack of specific remedies and devise responses appropriate to particular cases. Not least he will require to know when it is appropriate to say "he'll grow out of it" and when he must recognize that this will not happen unless appropriate help is given.

Is there a case for family doctors having special clinics when they can be consulted about the kind of problems described here, in the same way as so many practices now organize other kinds of special clinics? Possibly the greatest single contribution the family doctor can make is to do all he can to ensure that mothers, not least young mothers of pre-school children, are able to the best of their capacity, in good health and with enjoyment, to mother their children in the "good enough" way which is characteristic of the "ordinary devoted mother" (the quotations are from Winnicott).

Though there will be further expansion of psychiatric services and facilities for children, adolescents, and their parents, such services will never be able to undertake the assessment and treatment of all the children and young people who might be referred to them. There seems to be very little agreement about what the family doctor should do, is trained to do, or wants to do in the management of such problems. This dilemma might be partially solved, to the satisfaction alike of patients and professionals, if in each area family doctors and child psychiatrists were to try to work out their individual and joint responsibilities.

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One Hundred Years Ago

From the British Medical Journal, 17 August 1872

THE NEW LAW ON BABY-FARMING

The new Act for the better protection of infant life has been printed, and will come into operation on the 1st of November. The object of the new law is to guard against baby-farming. The houses of persons retaining or receiving for hire two or more infants, for the purpose of nursing, are to be registered. The age of an infant is under one year. The local authority of the place is to keep the register, and may refuse to register unless satisfied that the place is suitable, or the applicant of good character. A person so registered is to keep a register of all infants received, and to produce the same when required. A local authority, for serious neglect, or when a

person is incapable of providing proper food and attention, or if the house is unfit, may strike the name and house off the register. An inquest is to be held on an infant dying in a registered house unless a medical certificate is produced to the coroner. The punishment for an offence under the Act is not to exceed six months, with or without hard labour, or a fine of £5. Fines and penalties recovered are to go to the local rates. The statute extends to the United Kingdom, and the local authorities are specified. In the metropolis the Metropolitan Board of Works is the local authority, and in the City of London the Common Council.