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# Letter from . . .

## *Oslo*

SIMON R. WILKINSON, Consultant Psychiatrist (Child Psychiatry), Ullevål Sykehus, 0407 Oslo 4, Norway

It did not take me long to find that I belonged to the 'marginal' section of Norwegian society. Both as foreigner and psychiatrist I seemed to be a threat. Nevertheless it is from society's marginal groups that healers have often come (Miller, 1987) and so I continue to work with a necessary and natural cultural naivety and therapeutic optimism! I present here an overview and critique of the services provided for children in Oslo from the privileged position of a migrant. The high staffing levels and the profile of child and adolescent psychiatry appear to have exaggerated the 'psychologising' of problems and a search for therapy. These have the potential to inflame both interprofessional conflicts and interdisciplinary conflicts because of the emphasis on therapeutic skills to the relative exclusion of a relevant knowledge base.

Oslo is a city about the same size as Edinburgh with a population of about 450,000. Staffing in child psychiatry is high (Table I). The health services are sectorised so that different hospitals cover a collection of different city 'councils'. Child and adolescent psychiatric services are spread throughout the city with the aim of facilitating access for the most disadvantaged. Their administration is linked to their sector general hospital.

There are nine different out-patient departments, eight of which function independently of Oslo's in-patient department. The in-patient department does not admit children over 12 years old. There are possibilities for admission to an acute unit which admits in crisis and for a limited period, about four to eight weeks (five places), a day treatment unit whose treatment programme can often last up to a year (five places), a family unit which admits a whole family for day treatment for up to four weeks, or a day treatment nursery for children under school age, i.e. less than seven years old (five places). Oslo has so far not had as a priority the establishment of any in-patient provision for adolescents. The city here depends on the generosity of the adolescent in-patient unit of the National Centre for Child and Adolescent Psychiatry, Oslo, which has a responsibility to the whole country, for admissions of adolescents from 13 to 17 years old. Oslo has also had an arrangement to buy a few adolescent treatment places from the neighbouring county.

TABLE I

*Staffing in child and adolescent psychiatry out-patient services, Edinburgh compared with Oslo*

| | | | |
|---|---|---|---|
| Psychiatrists | 7 | cf | 19 |
| in training | 9 | cf | 11 |
| Psychologists | 5 | cf | 33 |
| in training placements | 3 | cf | 12 |
| Social workers | 6 | cf | 25 |
| in training placements | 4 | cf | 12 |
| Educational therapists | 0 | cf | 17 |
| in training placements | 0 | cf | 3 |
| Physiotherapist | 0 | cf | 1 |
| Total | 34 | cf | 133 |

There are also other admission facilities, not connected to the hospital department of child and adolescent psychiatry. These operate independently but with mandatory supervision from a child psychiatrist working in one of the out-patient departments. For example, there is another day centre for 7 to 14-year-old children with eight places, and one for 7 to 12 year-old children with eight places but with no clear differentiation of function. Politicians have determined that the three institutions for those with infantile autism are to be part of the child psychiatry services.

Then there are also those units for adolescents, literally translated as 'treatment homes', which embark on long-term treatment regimes, potentially up to several years. Their patients have usually had very poor care at home and the 'treatment home' functions as an alternative base, although a requisite for admission is that there is a 'home' base. They have often taken referrals direct from schools, PPT (see below) or child care, without child psychiatry being previously involved. One of these institutions has 18 places for 13 to 16-year-old adolescents and is situated an hour's drive from Oslo, and another has seven places for 15 to 19-year-old adolescents, as well as a halfway house with five places for those on their way out of greater independence. If one adds up all

the places, there is the potential for more than 60 places for those without autism.

In order to understand the culture of the field, it is necessary to give a little of the background to the training of the professionals, which gives them their particular profile within the service. Child psychiatrists are much rarer than clinical psychologists. Child psychiatry is not regarded as a subspecialty of psychiatry, but independent. Training is shorter than in Britain, consisting of a minimum of two years outpatient experience, one year with in-patients, one year in adult psychiatry, six months in paediatrics, and one year's free choice of relevant additional practice approved by the speciality. The minimum time to becoming recognised as a specialist, including seven years medical training, is therefore $12\frac{1}{2}$ years. A personal analysis is expected and further accreditation as a supervisor of 'psychotherapy' (here used to cover individual play therapy) is highly valued.

Although there are compulsory national residential training courses, there is much greater emphasis placed on developing the trainee's psychotherapeutic skills, particularly play therapy. Family therapy's advances into the field appear to have been relatively delayed. Child psychiatrists appear to have predominantly presented themselves as competent psychotherapists – ideally of the psychoanalytic kind, rather than being in a position to give helpful advice based on wide-ranging knowledge of the conditions they meet. After further training, many function analogously to child psychotherapists within British child psychiatry.

*Children in focus: there are seven nurseries (ca. 350 places) for children 0–6 years of employees at this general hospital. Most of the nurseries are open from 7.15 a.m. to 4.30 p.m.*

TABLE II
*Staffing in educational psychology, Edinburgh compared with PPT, Oslo*

| | | | |
|---|---|---|---|
| Psychologists/pedagogues | 21 | cf | 43 |
| Social workers | 2 | cf | 27 |
| Support teachers | 6 | cf | 16 |
| Total | 29 | cf | 86 |

A 'basic' university training in psychology lasts about seven years and includes much clinical psychology. At the end of this time those psychologists who wish to end up working in child psychiatry often apply for a position in PPT – the pedagogic/psychological advisory service. The PPT service has similarities to educational and child guidance services but it does not carry out treatment, and there are no doctors. Political decisions have limited the mandate of those working there to counselling. I include a few details of its staffing to illustrate that child psychiatry is not so highly staffed in order to cover a poorly staffed relative (Table II).

After psychologists have had two years relevant experience, such as in PPT or as a locum in a training post in child psychiatry, they can apply for a three year training post in child and adolescent psychiatry. When they have had two further years training in clinical psychology, they are then qualified as clinical psychologists with special competences in child psychiatry, i.e. a minimum of 14 years training in total. Like the child psychiatrists, many work analogously to child psychotherapists in Britain, and classical evaluation skills have had low priority.

A typical child psychiatry team also includes clinical pedagogues and social workers. The training for a clinical pedagogue, or educational therapist, involves a basic three year training at a teacher training college, five years experience – of which two must be with children with psychological difficulties, two years of specialised further pedagogic training prior to a final three years in a training post in 'educational therapy', i.e. a minimum of 13 years in total.

Both social workers and educational therapists are unlikely to have had a university education. Social workers in child psychiatry will have begun their training with three years at a training college. Before

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they can apply for a three year training post to be a 'clinical social worker in child psychiatry' they have to have had a minimum of two years experience, such as in a social work office, adult psychiatry or PPT. Because there are clear official guidelines in Norway for ranking applicants for all posts in relation to total and kind of experience, with less emphasis given to references, it has often meant that social workers have had up to eight years experience before getting a clinical training post. Their minimum training will have been eight years.

Political decisions have determined who can describe themselves as a therapist. As social workers and educational therapists (the designation only creeps in in translation) are excluded, many rivalries have blossomed in the prevailing pseudodemocratic climate of a typical out-patient department. The appointed leaders are politically determined to be either a psychologist or psychiatrist for an out-patient department, whereas for in-patients there is dual leadership of the senior psychiatrist and senior nurse. Typically a leader has been regarded by the team as having a solely titular post without power. This has been aided and abetted by politicians and hospital directors who have made few demands of their leaders. Who works with which referral has often been determined by personal whims. This practice appears to flourish in a setting where undue emphasis is given to being seen as 'understanding'. There seems to be little differentiation between therapeutic stances – here often those particularly useful in individual play therapy with young children with neurotic problems – compared to administrative approaches, as the 'therapeutic' approaches often seem to be used to facilitate working together in a team instead of resorting to administrative leadership skills. The field has become full of many half sleeping conflicts. This has resulted in it being particularly difficult to establish a new leadership culture which will make its priorities for the field clear on the basis of easily understood rationales. This requires a much greater knowledge about the scientific basis of the field.

Oslo City Council is attempting to introduce goal-directed leadership and effectiveness in a climate of financial restraint. Unfortunately the politicians have decided to protect child psychiatry, virtually the only specialty to be so protected, from cutbacks, and so one of the creative tensions which could have facilitated leader development and debate about priorities for the field are still largely lacking. Instead other initiatives which central government have been taking to improve the quality of treatment throughout the health service will hopefully lead to some necessary reflection about therapeutic effectiveness and choice of approach. I believe that it must be possible to improve radically the service through reorganisation, redistribution of professionals between the various children's services, and in particular well formed demands from the politicians.

What will happen when the politicians check up how their money is being spent and begin to interest themselves in the details of the services? The first signs are being noted with the 1992 change in the dominant political party in the city. The new advisers to the council are exploring ways of linking child psychiatry to the child care and protection services, currently part of the social work services. Underneath are similar dynamics which led to the spate of government reports on administration of the health service in Britain. Development in child psychiatry is dependant on similar critical analyses, and administrators who have the nous to ask the interesting questions and are brave enough to tolerate the wrath of the specialty.

As a migrant I continue to be thought of as vaguely contaminating the purity of Norwegian child psychiatry. My reflections on British child psychiatry are not as innocent as they were. The privileged observations I have made, similar to those of an anthropologist entering a strange culture (see particularly Douglas [1966] on 'Purity and Danger'), suggest that I am witnessing a marked psychologising of Norwegian society. What the consequences of this will be for the country's future wellbeing will be revealed in the next 20 years. I do not believe that Norway can continue to afford the ways of accounting for children's behavioural deviances which it has developed, and which have fuelled this particular 'triumph of the therapeutic' (Rieff, 1966). But can Britain continue to give child psychiatry such a low priority?

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