Fund-holders and child mental health services

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Three hundred randomly selected fund-holding general practitioners were sent a questionnaire that asked them to indicate their priorities for child mental health services. They were also asked to rate their local child mental health services; 210 (70%) returned completed questionnaires. Items accorded the highest priority by the largest number of GPs included written communication, short waiting time following referral, sensitivity to patient's cultural background, child sexual abuse services, and mental handicap services. Child psychiatrists were seen as the most essential members of multidisciplinary teams, and family therapy was the most popular choice of treatment. Financial considerations did not appear to dictate GPs' choices. About half of respondents rated their local services as barely satisfactory, unsatisfactory or extremely unsatisfactory.

A general practitioner sees a child three to seven times a year and is well placed to assess the needs of children with psychological disorders. Priorities set by GPs are important because they reflect local needs. It is not therefore surprising that providers have been urged to establish priorities that are sensitive to the views of GPs.

Recent NHS reforms have increased the influence of GPs on the development of both primary and secondary care services. In addition, the appointment of fund-holding practices who are direct purchasers has made it possible for GPs to influence the pattern of specialist services. Their influence is bound to increase with the withdrawal of opposition to fund-holding by the General Medical Services Committee (GMSC) and because as from April 1994, 40% of GPs became fund-holders. This is the first study in the UK to determine fund-holders' priorities for child mental health services.

The study

During May and June 1993, 300 fund-holding practices were chosen using a random numbers table from a list of first and second wave practices in the UK (Institute of Health Services Management, 1993). One GP was chosen from each of the 30 practices using a random numbers table (Daniel, 1991) and was sent a questionnaire together with a personally addressed covering letter. Three weeks later another questionnaire was sent to GPs who had not responded.

The questionnaire had a list of services, treatments and professionals relevant to child mental health. GPs were asked to rank each item as priority or essential; important, but not essential; not important. If they did not have sufficient knowledge they were asked to tick the column headed 'no comment'. One section was left blank for respondents to add items not on the list.

To determine whether or not financial factors influenced GPs' attitude to treatments or professionals, respondents were asked to rank the following items: all professionals involved with a particular child should be charged for separately (rather than one fee to cover all professionals); all treatments given to a child should be charged separately (rather than one fee for all treatments); and that no extra treatments, unless previously agreed, should be given without prior consultation.

GPs were also asked to rate their local child mental health services as: excellent; very good; good; barely satisfactory; unsatisfactory; extremely unsatisfactory.

A final section invited GPs to make additional comments on their child mental health services.

Findings

Out of 300 (70%) GPs, 210 returned completed questionnaires. The commonest reason given for non completion of questionnaires was lack of time.

Table 1 shows the types of services fund-holders regarded as priorities in child mental health services. Service items seen as priorities

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Table 1. Fund-holders' priorities for child mental health units: services and specialities. Numbers (%) refer to general practitioners

	GPs' views (*n*=210)		
Services or speciality	**Priority/essential**	**Important but not essential**	**Not important**
Written reports	160 (88.0)	36 (17.1)	6 (2.9)
Short waiting time after referral	158 (75.2)	51 (24.3)	1 (0.5)
Child sexual abuse service	158 (75.2)	52 (24.8)	0 (0.0)
Sensitivity to client's culture	127 (60.4)	71 (33.8)	10 (4.8)
Mental handicap	125 (59.5)	79 (37.6)	6 (2.9)
Emergency in-patient beds	111 (52.9)	74 (35.2)	25 (11.9)
Alcohol and drug addiction	100 (47.6)	102 (48.5)	6 (2.9)
Youth counselling	92 (43.8)	108 (51.4)	10 (4.8)
Appointments made over telephone	89 (42.4)	102 (48.5)	19 (9.1)
In-patient beds (13 to 17 years)	86 (41.0)	103 (49.0)	21 (10.0)
Overdose assessment	78 (37.1)	113 (53.8)	17 (8.1)
In-patient beds (0 to 12 years)	62 (29.5)	111 (52.9)	37 (17.6)
Day hospital (13 to 17 years)	61 (29.0)	118 (56.2)	31 (14.8)
Day hospital (0 to 12 years)	60 (28.5)	110 (52.4)	37 (17.6)
Out of hours/weekend service	27 (12.8)	119 (56.7)	64 (30.5)
Practice based regular meetings	15 (7.1)	119 (56.7)	76 (36.2)
Joint assessment of patients	9 (4.3)	93 (44.3)	108 (51.4)

by the greatest number of GPs were written reports and a short waiting time after referral. The specialist service seen as a priority by the greatest number was the assessment and treatment of sexually abused children. Joint assessment of children and regular practice visits by child psychiatrists came at the bottom of the priority list.

Table 2 shows fund-holders' priorities for child mental health professionals. Child psychiatrists were at the top of the priority list and music therapists at the bottom.

Table 3 shows the types of treatment fund-holders thought should have priority. Family therapy was seen as a priority by the greatest number of GPs.

Tables 2 and 3 also show how GPs rated financial factors.

Of the 210 GPs, three (1.4%) rated their local child mental health service as excellent, 16 (7.6) as very good, 79 (37.6) as good, 67 (31.9) as barely satisfactory, 33 (15.7) as unsatisfactory, and 12 (5.7) as extremely unsatisfactory.

Out of 210 GPs, 40 (19%) indicated further concerns in additional comments on local services. Thirty (14%) commented on poor resources and long waiting times after referral. Twenty (10%) indicated their dissatisfaction with communication: no written reports on children seen; vague summaries; too much theory; and the lack of

Table 2. Fund-holders' priorities: child mental health services staff. Numbers (%) refer to general practitioners

	GPs' views (*n*=210)		
Professional	**Priority/essential**	**Important but not essential**	**Not important**
Psychiatrist	188 (89.5)	19 (9.0)	3 (1.5)
Psychologist	166 (79.0)	39 (18.6)	5 (2.4)
CPN	157 (75.1)	46 (21.9)	7 (3.0)
Social worker	141 (67.1)	59 (28.1)	10 (4.8)
Psychotherapist	126 (60.0)	69 (32.9)	12 (5.7)
Art therapist	6 (2.9)	74 (35.2)	124 (59.0)
Drama therapist	5 (2.4)	68 (32.4)	131 (62.3)
Music therapist	4 (1.9)	71 (33.8)	129 (61.4)
Separate charges for professionals who see a child	38 (18.1)	80 (38.1)	92 (43.8)

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Table 3. Fund-holders' priorities for child mental health services: treatment methods. Numbers (%) refer to general practitioners

	GPs' views (*n*=210)		
Treatment	**Priority/essential**	**Important but not essential**	**Not important**
Family therapy	139 (66.2)	66 (31.4)	4 (1.9)
Counselling	106 (50.5)	98 (46.7)	5 (2.3)
Behaviour therapy	59 (28.1)	120 (57.1)	29 (13.8)
Marital therapy	51 (24.3)	114 (54.3)	41 (19.4)
Play therapy	34 (16.2)	119 (56.7)	54 (25.7)
Group therapy	26 (12.3)	141 (67.1)	39 (18.6)
Analytic therapy	19 (9.1)	99 (47.1)	92 (43.8)
Art therapy	15 (7.1)	100 (47.6)	93 (44.3)
Drama therapy	5 (2.4)	91 (43.3)	113 (53.8)
Music therapy	3 (1.4)	97 (46.2)	110 (52.4)
Acupuncture	1 (0.5)	23 (11.0)	185 (88.0)
Homeopathy	0 (0.0)	26 (12.4)	183 (87.1)
Cost treatments separately	50 (23.8)	84 (40.0)	73 (34.8)
No extra treatments without telling GP first	46 (21.9)	69 (32.9)	92 (43.8)

practical suggestions. One GP indicated that his practice was so dissatisfied with the local service that negotiations had began to establish a contract with a unit in another area.

Comment

This study shows that child mental health units should pay attention to written communication and waiting time after referral at their audit meetings.

Nearly two-thirds of fund-holders regarded sensitivity to the client's cultural background as a priority. This is bound to be an important factor in the quality of service provided to ethnic minorities and is consistent with a recent suggestion that training in ethnic issues should be available to child psychiatry senior registrars (Nicol, 1992).

A striking finding was that child sexual abuse work was chosen as a priority service by a high number of GPs. The choice is supported by studies that have shown that child sexual abuse is much more widespread than previously thought (Baker & Duncan, 1985; Anderson *et al*, 1993) and associated with childhood psychological problems (Mannarino & Cohen, 1986) as well as psychiatric disorder in adulthood (Beitchman *et al*, 1992). Intrafamilial sexual abuse probably places a GP whose list includes abusing and abused family members in a difficult position.

The high priority given to sexual abuse services suggests that GPs want to be able to pass on complex cases to their local service. Another possible factor is that the Children Act (1989) emphasises working with parents (partnership) and fewer cases reach the courts. GPs may therefore be put under pressure to arrange assessment and treatment for cases that would have otherwise been dealt with by the courts. Clearly the lack of local expertise is keenly felt. The increased awareness of sexual abuse in the population, and the rise in the number of reported cases indicate that sexual abuse is set to become a significant part of the GPs' work-load.

The emphasis on mental handicap services is probably a reflection of the resettlement into the community of people with learning disabilities and the resultant demands made on the general practitioner to manage challenging behaviours.

Given the interest in children admitted to adult psychiatric wards (Dyer, 1992; Malek & Children's Society, 1991), it was surprising that only 30% to 40% of fund-holders thought in-patient or day services a priority. Perhaps in-patient care is perceived to have disadvantages such as disruption of the child's usual environment; and the value of child psychiatric inpatient treatment is uncertain, even among child psychiatrists (Allesi, 1993; Pfeiffer *et al*, 1990). Possibly also the number of children who require in-patient or day hospital care is so small that an individual general practitioner probably sees so few that there might seem no great need for such services.

Child psychiatrists are seen as the most essential member of the child mental health team. This suggests that the psychiatrist is

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viewed as the most powerful member of the multidisciplinary team even though team members may regard all team members as equal. Alternatively, GPs may identify with the medical member of the team, and are not sure what role non-medical members of the team have. Furthermore, those GPs who apply the 'medical model' to childhood psychological disorders probably regarded non-medical members of the team as less essential.

Sixty per cent of GPs regarded art, drama or music therapists as of no importance. By contrast, the child psychotherapist was seen as a priority by 60% of GPs. This suggests that child mental health units will find it easier to get fund-holders' support for the recruitment of child psychotherapists than for art, drama and music therapists.

That family therapy was given such a high priority suggests that GPs regard psychological problems in children as having a family basis and were perhaps also influenced by the knowledge that most child psychiatrists favour family interventions.

That shorter term structured behavioural methods were ranked third even though they are cheaper suggests that economic factors did not dictate choice of treatment. Moreover, only a fifth of GPs thought it essential that professionals or treatments associated with a particular child be charged for separately or that extra treatments should not be given without prior consultation.

These findings are important for several reasons. The consultation fees for a professional who sees fewer children than others, for example a psychotherapist, may be considered too high if costed separately. Setting a standard unit fee makes it possible for child mental health units to charge lower fees because professionals who see more children, or receive a lower salary, help subsidise those who do not. Different treatments are unlikely to cost the same, and more expensive treatments disproportionately raise the cost of a package that consists of several different types of therapy. A child seen by one mental health unit may require additional treatments from another specialist unit which may be delayed if a fund-holding practice insisted on being consulted before additional treatments are given.

Only a fifth of fund-holders thought joint patient assessment or regular meetings with a child psychiatrist were priorities and a half thought joint patient assessment of no importance (cf. Brown & Tower, 1990). This suggests that child psychiatrists may find it difficult to establish face to face links with fund-holding practices.

It is worrying that about half of GPs rated their local services as barely satisfactory, unsatisfactory or extremely unsatisfactory and all the more striking because the practitioners came from all over the UK.

Child mental health units must plan services that are sensitive to the needs of their clients and the views of GPs. The balance of power has now shifted from providers to purchasers and secondary care units cannot ignore the opinions of GPs, the major purchasers of services.

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