kind. During the preliminary discussions I have frequently been asked for reassurance that the anticipated costs of the new procedure will not place an unreasonable burden on the profession — preliminary estimates suggest that, in the early years, the introduction of the procedure is likely to add no more than between £5 and £10 to the annual retention fee.

I was encouraged by the wide support in principle which the proposals have received among both the professional and other organizations consulted. I believe that the proposals are seen as demonstrating the ability of the profession to continue to regulate itself effectively. The GMC will now begin work on developing the procedures in much more detail, and there will be further wide consultation on that detail before the procedures are finally implemented.

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Psychiatric morbidity in children and adolescents: a suitable cause for concern

THE scope of British health care practice, the structure of the health service and the roles of both primary and secondary health practitioners have changed dramatically, particularly in the last five years, and will continue to do so (NHS and community care act 1990).[1] Few would not applaud the move of specialized care closer to where people live and work, though many professionals have expressed concern about whether or not the mechanisms currently being employed to promote care in the community and, in particular, the new funding arrangements from April 1993, will prove equitable, effective and safe. The shift towards an increasing status for prevention and health promotion is clearly signalled by the new contract for general practitioners, the health service reforms and, most recently, by the white paper *The health of the nation.*[2] Inevitably, the boundaries between primary and secondary care are having to be redefined and new alliances forged.

It is against this background that I call for increased awareness among general practitioners of the emotional needs of children generally and for the improved recognition and treatment of those children suffering psychiatric disorders, in particular. There can be no doubt about the importance of the problem. The level of psychiatric morbidity in young people is high and the majority of those suffering remain unrecognized and untreated. In the 1990 Robina Addis memorial lecture Rutter summarized the situation when reviewing the prevalence of childhood psychiatric disorder, the evidence suggesting increasing rates and links with mental conditions in adult life.[3] He concluded by emphasizing the potential seriousness of psychiatric disorders in childhood.

As in other areas of practice, the general practitioner is expected to deal with a major proportion of psychiatric morbidity among children and adolescents, and yet the training that most medical graduates have received in child and adolescent psychiatry in the past has amounted to familiarization, at best, though this situation is now improving.[4] At the same time there is growing concern about the extent of many secondary level mental health services for children and adolescents.[4,5] The training of those professionals working in this field has developed rapidly, as has the quality of those recruited.[4] Rutter gives a clear picture of the enormous gains made in the understanding of child development and the nature of child psychiatric morbidity, and in the treatment of this morbidity in the last 50 years or so.[3] Nevertheless, specialist services have developed unevenly and were caught at a sensitive point in their evolution by greater economic austerity after the mid-1970s.[4] Many specialists have been, and are, concerned that the present reforms of the health service could exacerbate the vulnerability of mental health services for children and adolescents, if the market pressures brought to bear are not effectively managed.[5] On the other hand it is equally possible that, if the market is well managed, there might be new opportunities for further development.

Needs assessment and health gain assessment are now public health and health economic techniques, respectively, central in the new commissioning process, inherent in the strategic approach to determining the work of the health service in the United Kingdom which arises as an important component of its reform begun in 1990 (NHS and community care act 1990). General practitioners have an increased role in determining the pattern of services, whether or not they are fundholders, and so are faced with the task of formulating their opinions of the needs of their patients. A mental health needs assessment survey conducted in one district showed that families, general practitioners and specialists had differing perceptions of which children would benefit from referral, and also demonstrated a significant shortfall in specialist resources (Evans SC, Brown RMA, paper presented to a seminar on child and adolescent mental health services, Royal College of Physicians, London, March 1992).

While an increase in specialist resources is clearly necessary, it is unlikely that these resources will be dramatically increased in the 1990s. Nevertheless, it should be possible to influence changes in service delivery patterns and targets, and to encourage the practical developments in service style which are now required. Important initiatives are already under way. Action for Sick Children published *With health in mind* in 1992.[6] This contains three papers presenting models for the commissioning and provision of mental health services for children and the involvement of users in specifying and monitoring such services. While much of the document relates to specialist services, it also contains information which primary health care practitioners will find useful in defining the nature of childhood psychiatric disorder and the types of service which they might provide, purchase (if fundholders) or advise health authorities to purchase.[7] A helpful summary has been published as a briefing paper by the National Association of Health Authorities and Trusts.[8]

Rutter has drawn attention to the rapidly developing academic base of child psychiatry, and primary care research conducted by, or in association with, general practitioners is a vital component.[3] In this issue of the *Journal,* Bowman and Garralda draw attention to how common child psychiatric disorder is and the frequency with which its sufferers present with physical symptoms to general practitioners.[9] Their principal finding is that psychiatric disorder is much more common among frequent attenders than non-attenders at general practice surgeries. If this were to hold true in other areas of the UK then a substantial number of children suffering psychiatric disorder are already in contact with general practitioners and, appropriately, Bowman and Garralda recommend targeting this group. This demonstrates that general practitioners could make an impor-

tant contribution to enhancing the recognition of psychiatric disorder in children without greatly changing their practice.

But how are general practitioners to respond after recognizing a psychiatric disorder? Effective intervention is important and while the adage, 'He (or she) will grow out of it', can be true for those children suffering brief, mild distress, it is much less likely to be so for those suffering symptoms of three or more months' duration which are causing increasing social and developmental problems. Recognition itself can be an effective intervention in some cases, resulting in containment, the mobilization of family resources and a reduction of the risks of somatization. However, there is also a need for much greater collaboration between primary and secondary practitioners. Early contact can result in discussion of treatment plans leading to effective primary care intervention, increasing confidence among general practitioners and more rapid treatment of those with serious disorder through better case selection. Child and adolescent psychiatrists, in particular, must continue to develop links with general practitioners. Improved communication could be achieved through greater availability of specialist mental health practitioners on the telephone, to cite just one example. General practitioners often tell me that they value this style of contact. Specialist practitioners must continue to develop a range of interprofessional consultation skills, and the time allocated to the provision of these services must be valued by purchasers, whether they be general practitioner fundholders, family health services authorities or district health authorities.[10,11] None of my suggested developments will resolve the strategic and resource problems for mental health services for children and adolescents but improving the recognition and management of mental health problems in the young in primary health care and closer contacts between these services and specialist practitioners are likely to make a substantial contribution to improving the well being of many children and will simultaneously, challenge the stigma of mental illness.

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