PERSONAL VIEW

District handicap teams in England: 1983-8

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The need to study a wide range of attributes and functions when assessing a disabled child has long been recognised. The concept of the multi-disciplinary investigation of children with behaviour disorders led to the opening of child guidance clinics first in the United States and then in this country in the 1920s. Paediatricians in the 1940s and 1950s were able to pay more attention to the complex chronic disabilities, and special combined clinics were set up. These early ventures led to recommendations about the way such clinics might be run.¹ So in a higgledy piggledy way services for disabled children were beginning, but they were being planned in isolation, and were initially exclusively for children with specific disorders; the notion of a service for all disabled children was embryonic.

The idea of health and education authorities together planning combined facilities for the investigation, treatment, and special education of young, disabled pupils was also new. In the absence of alternative arrangements local education authorities had been opening their own diagnostic and assessment units; these often operated independently of hospital specialist facilities and without appropriate support services.^{2 3}

Acting on a recommendation in the Sheldon report on child welfare centres that health authorities should be asked to review their arrangements for the assessment of handicapped children,⁴ the then Ministry of Health issued a memorandum containing the advice of 'a small group of experts' on the setting up of comprehensive assessment centres for children with all types of handicap.⁵ The ministry set aside special funds to help regional hospital boards finance such centres and by 1973 there were 52 either in existence or being built.

The Court report went further.⁶ Concerned at the constant failure of clinics specialising in single disabilities to offer a wide assessment of development and residual functions of referred children, the report recommended that each health district, with the support of local education and social service authorities, should organise formally a multidisciplinary team for all handicapped children as a central feature of its comprehensive services for handicapped children. It was also convinced that these 'district handicap teams' should have integrated facilities for prevention and treatment as well as for assessment, and that they should have an operational role as well as a clinical function. By an

operational role the committee meant that the district handicap team should be concerned with other district staff in epidemiological surveys and in the identification of disabled children, and in monitoring its own effectiveness; it should also act as a district resource centre for handicap in childhood.

The committee suggested that the district handicap team should comprise a consultant community paediatrician, a child health visitor for handicapped children, a specialist social worker, a principal psychologist, and a teacher with wide experience of handicapped children of nursery and infant school age. As a secondary (specialist) service the district handicap team would then see the minority of handicapped children who had complex or severe disorders (or both). It would work both within and from a child development centre, which itself would be situated in or near the district's general hospital. It would be in support of similarly integrated primary care services geared to meet the needs of most handicapped children.

The government of the day accepted in principle that 'district handicap teams should provide a framework within which all the needs of the relatively few children with severe handicap, both physical (including sensory) and mental can be met. . . ' and it invited health authorities to draw up joint proposals with education and social service authorities for their organisation and operation.⁷ As it simultaneously sanctioned the establishment of community teams for mentally handicapped children and adults, however, in practice it clearly had some reservations about relying on district handicap teams to meet all the needs of all severely handicapped children. The recommendation for 'cradle to the grave' community mental handicap teams had been made by the National Development Group (an advisory body set up by the government in 1975 to look at services being offered to mentally handicapped people), which feared that it would be some time before district handicap teams could become operative but community mental handicap teams could be set up at once.

As their report was reprinted in November 1983 we assume it still represents official policy, just as presumably DHSS circular HC(78)5 did, in so far as it has not been officially withdrawn.⁸ What influence this departmental ambivalence may have had on the development of district handicap teams (and community mental handicap teams for that matter) must

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remain a matter for conjecture. We note, however, that in summing up the results of a limited survey of both kinds of team conducted on behalf of the Campaign for Mentally Handicapped People, Plank emphasised the need for district handicap teams to be more clearly based on the Court committee pattern, and for community mental handicap teams to confine their services to adults only.⁹

It was against this background that we had an opportunity to carry out a postal inquiry of every district health authority in England in 1983, supplemented by visits to a few selected districts, to find out how far district handicap teams had been established and how they were working. Of districts contacted, 94% completed a questionnaire. This asked whether the district had a handicap team and also whether it had a children's assessment centre; it went on to ask detailed questions about such units and inquired whether any changes were being planned; it concluded with a request for a brief statement about the overall pattern of services for handicapped children in the district. This first inquiry was sponsored by the DHSS to whom we reported the next year.¹⁰

In 1988 we again made contact with each health authority (98% replied; two no longer existed after the second reorganisation of the NHS in 1984). They were asked if the changes contemplated for their handicap team or assessment centre had materialised. Districts that had established a district handicap team since 1983 were subsequently asked to complete the original questionnaire that had been issued in 1983. Descriptions of a 'district handicap team' or an 'assessment centre' were checked against those listed in the Social Services Year Book for 1989/90, and discrepancies were investigated by writing to the consultant paediatrician concerned.

It was as a result of these subsequent inquiries that we fully appreciated how much confusion existed as to what is meant by a 'district handicap team'. Looking back this was probably the reason why the questionnaire completed in 1983 gave the impression that there were 119 district handicap teams in England,

whereas from information supplied by district medical officers to an initial inquiry we had expected there to be 100 (nine district medical officers did not reply). We had assumed (mistakenly it now seems) that the difference was the result of an administrative rather than a technical error.

In 1988, therefore, we set down the minimum criteria that we felt justified the classification of a unit in 1983 as a Court type district handicap team, and with this in mind we looked again at the questionnaires returned in 1983. The revised results are published here for the first time and differ in important respects from those reported earlier. We also now report on some of the changes that have taken place during the last five years.

Revised analysis of 1983 data

CLASSIFICATION AND DISTRIBUTION OF UNITS

The minimum criteria we adopted for classification of a unit as a district handicap team based on our interpretation of the Court report was: the existence of a multidisciplinary team of practitioners who were personally engaged in the clinical assessment and care of individual handicapped children domiciled within the district, and personally concerned in the team's operational responsibility for providing a regular service. It should also act as a resource centre to other people or institutions caring for such children, and monitor its particular contribution to the district's services for all handicapped children. Applying these criteria in retrospect, only 61 districts (32%) could in our opinion be said to have had a Court type district handicap team in 1983 (table 1).

As a result of this reclassification we encountered two other types of unit calling themselves district handicap teams, neither of which satisfied the above criteria. The first type provided facilities for the clinical assessment (and to some extent care) of handicapped children by a multidisciplinary team of practitioners, but only for those living in the local community; they had not been set up to meet the needs of the district

Table 1 Regional distribution of units (England 1983)

Region	No of district health authorities	No of district health authorities having:					No that did not reply
		District handicap team	Assessment centre	District coordinating group	Separate assessment centre and district coordinating group	Nil units	
Northern	16	4	2	4	2	2	2
Yorkshire	17	7	3	0	1	4	2
Trent	12	2	5	1	2	2	0
E Anglia	8	2	1	1	0	4	0
NW Thames	15	4	2	5	1	2	1
NE Thames	16	7	3	2	1	3	0
SE Thames	15	7	3	0	2	3	0
SW Thames	13	3	3	0	5	0	2
Wessex	10	1	3	1	2	3	0
Oxford	8	3	2	0	0	2	1
S Western	11	4	3	2	1	1	0
W Midlands	22	5	11	0	1	4	1
Mersey	10	3	0	4	0	1	2
N Western	19	9	3	1	2	3	1
Total (%)	192	61 (32)	44 (23)	21 (11)	20 (10)	34 (18)	12 (6)
Predominantly rural districts	85	23	19	7	10	20	6
Predominantly urban districts	85	33	21	7	9	5	10

as a whole, nor had they assumed an operational role in respect of handicapped children throughout the district. Forty four districts (23%) had this type of unit; we have classified it as an assessment centre, which is what many of them were actually called (table 1).

The second type consisted of a group of professionals not all of whom were personally concerned in the clinical care of individual children or were even clinical practitioners, but who nevertheless made decisions about the coordinated care or education (or both) of individual handicapped children. Often they would meet and discuss children named on a register, relying on information supplied by other professionals; they may or may not have had an operational role in respect of the district's services for handicapped children. Twenty one districts (11%) had such a group, which we have classified as a district coordinating group in table 1. Twenty districts (10%) had at least one assessment centre as well as a district coordinating group, but the two services did not function together and often there was only one person (usually a doctor) attending both.

A number of districts explained that as they were serving a rural community one central team was seldom appropriate. Quite arbitrarily we picked out 'the predominantly rural' and 'the predominantly urban' districts; by coincidence we found we had selected 85 districts in each group. The distribution of units in these two kinds of district is compared at the foot of table 1. The urban districts were a little more likely to have a district handicap team than the rural districts (39% and 27%, respectively) but the other types of unit were equally common. Rural districts, however, were from two to four times more likely not to have any type of unit at all.

The 1983 questionnaire also asked whether the district had a community mental handicap team; 132 (69%) said they did but of these only 74 (56%) accepted children. Thirty nine of the 192 districts (20%) said they did not have such a team, and 21 did not answer this question.

DISTRICT HANDICAP TEAMS AS OPERATIONAL UNITS

Of the 61 units we reclassified as Court type district handicap teams, 49 (80%) stated who made up their 'core' team. The mean size was seven members (range 3–10); in all, 29 different professions were named and there were 44 different combinations of membership of which only five occurred twice. Certain disciplines predominated (table 2).

We asked if the district handicap team had a 'formal team leader' and 46 (75%) said it did: in 51 (84%) of them a doctor was named, usually a paediatrician rather than a senior clinical medical officer (ratio 2:1). In seven (11%) leadership was shared or rotated among the core members.

We specifically asked about three kinds of operational work. Four out of five district handicap teams met regularly to discuss the way their service was running and plans for the future. Appreciably fewer provided regular services to other people or institutions: 32 (52%) to day

Table 2 Number (%) of district handicap teams (n=61) that mentioned the professionals who were core members

All five disciplines laid down by Court committee	15 (25)
No mention made of:	
Consultant paediatrician	9 (15)
Health visitor	11 (18)
Social worker	17 (28)
Psychologist	19 (31)
Teacher	36 (59)
Others considered core members:	
Physiotherapist	41 (67)
Speech therapist	36 (59)
Senior clinical medical officer	35 (57)
Occupational therapist	29 (48)

nurseries and 10 (16%) to schools. In addition to this team members were quite prepared to see referred children in places other than the child development centre. Thus 44 teams (72%) said they would visit them when necessary at home, 49 (80%) at a day nursery, 42 (69%) at a special school, 38 (62%) at a primary school, and 32 (52%) at a secondary school.

The third operational task we asked about was the organisation of seminars and training courses. Forty five district handicap teams did this (74%) though to fulfil our classification of a district handicap team they had to do more than just this; only 24 (39%) undertook all three specific operational tasks.

DISTRICT HANDICAP TEAMS AND ASSESSMENT CENTRES AS CLINICAL UNITS

The clinical functions of a district handicap team are essentially no different from those of an assessment centre. The rest of the information reported here is therefore derived from questionnaires returned to us by the 61 districts we regarded as having district handicap teams and the 64 districts that had assessment centres. We have used the term 'child development centre' to cover all these 125 units that provide a personal clinical service.

Thirty three child development centres (26%) had been functioning for nine years or more (some for as many as 20 years); the same proportion had been open for five to eight years, and the same for one to four years. Eight centres

Table 3 Range and frequency of sessions by professional staff in child development centres

	No (%) of all centres (n=125)	Average No of sessions (63 centres)
Seven most commonly named professionals:		
Paediatrician	100 (80)	3.2/week
Senior clinical medical officer	96 (77)	3.2/week
Physiotherapist	101 (81)	6.7/week
Speech therapist	100 (80)	4.7/week
Social worker	85 (68)	4.5/week
Health visitor	84 (67)	2.4/week
Occupational therapist	79 (63)	4.2/week
Four other professionals named by about half the centres:		
Educational psychologist	66 (53)	1.1/week
Clinical psychologist	60 (48)	1.6/week
Teacher	60 (48)	4.4/week
Audiologist	60 (48)	3.0/month
These less often mentioned:		
Nurse	54 (43)	7.6/week
Orthopaedic surgeon	40 (32)	1.3/quarter
Ophthalmologist	28 (22)	1.4/quarter
Mental handicap specialist	25 (20)	1.8/quarter
Child psychiatrist	24 (19)	2.1/month

(6%) had been open for less than one year and the remainder did not say. Eighty (64%) were sited in (or in the grounds of) the district general hospital, and 18 (14%) were in a health service clinic. Fifteen (12%) were separate from both these and 12 (10%) did not say.

Table 3 shows how many centres had regular sessions from certain professionals and (among 63 centres) their average frequency. Ninety three centres (74%) had sessions from both paediatricians and senior clinical medical officers; 38 (30%) from health visitors and nurses; and 36 (29%) from both educational and clinical psychologists. Table 3 also shows the multidisciplinary facilities available at centres, but we

wanted to know whether they were used for treatment as well as for assessment. Physiotherapy and speech therapy were carried out in 101 of the centres (81%) and occupational therapy in 94 (75%); day care and remedial teaching was provided in 71 (57%) and 70 (56%), respectively. Table 4 shows the extent to which children received wideranging assessment.

Ninety four (75%) of the districts that had a child development centre also had a community mental handicap team, though only 56 (60%) of the latter accepted children. In the 56 districts that had both these facilities, 38 of the child development centres (68%) said that they also saw children who attended the community mental handicap team.

Some centres commented that who the child was assessed by would depend upon the reason for referral. Fifty centres gave information about the number of children with various problems seen during the past year, and the data are summarised in table 5.

Age is an important factor to be borne in mind when looking at the data presented here. We did not feel we could burden the centres by asking the age of each child referred; instead we asked the age range that they accepted. Twenty nine of the 125 centres (23%) would only see children up to the age of 5, 76 (61%) would see any child under school leaving age, and 14 (11%) set various age limits between 5 and 16. Thirty four centres (27%) said they would see young people at least up to the age of 18, and 26 (21%) would see 19-20 year olds if necessary.

The principal sources of referral were paediatric outpatients (n=76, 61%) clinical medical officers (n=59, 47%) and neonatal follow up clinics (n=46, 37%); general practitioners and health visitors were each named by 41 centres (33%). Direct referrals were accepted from health visitors by 47 centres (38%), from social workers by 40 (32%), and from teachers by 31 (25%). Parents had direct access to 36 of the centres (29%); they took part in the running of 21 centres (17%), mainly in organising the toy library.

Table 4 Number (%) of child development centres (n=125) offering multidisciplinary assessment to 'most' children

Assessment by:	
Paediatrician	107 (86)
Senior clinical medical officer	90 (72)
Physiotherapist	90 (72)
Speech therapist	90 (72)
Audiologist	81 (65)
Psychologist	79 (63)
Occupational therapist	60 (48)
Teacher	42 (34)

Of the 90 centres at which there were sessions from both a paediatrician and a senior clinical medical officer, in 81 (90%) 'most children' were assessed by both.

Table 5 Problems for which children were referred to 50 child development centres during the previous 12 months

Problem	No of children	% Of total referrals
Mental handicap (including Down's syndrome, n=344)	1650	25
Learning difficulty	483	7
Developmental delay	391	6
Cerebral palsy	781	12
Spina bifida	278	4
Speech and language	938	14
Vision	313	5
Hearing	270	4
Behaviour	560	9
Epilepsy	417	6
Asthma	236	4
Muscular dystrophy	108	2
Miscellaneous (each less than 100)	161	2
Total	6586	100

Table 6 Changes in units and districts between 1983 and 1988

Type of change	No of units or districts reporting changes and No of changes made						Total among 94/192 units or districts
	Among 32/61 district handicap teams	Among 22/44 assessment centres	Among 7/21 district coordinating groups	Among 11/20 separate assessment centres and district coordinating groups	Among 15/34 districts with no facilities initially	Among 7/12 districts that did not reply initially	
More sessions from various staff	51	31	4	12	0	0	98
Improvements to accommodation	12	7	0	1	0	0	20
Improvements in facilities	14	5	0	3	0	0	22
Change in classification:							
To a district handicap team	—	0	3	0	—	—	3
To a separate assessment centre and district coordinating group	0	1	0	—	—	—	1
Opened since 1983:							
District handicap team	—	—	—	—	5	2	7
Assessment centre	—	—	—	—	5	4	9
District coordinating group	—	—	—	—	1	0	1
Separate assessment centre and district coordinating group	—	—	—	—	4	1	5
Total No of changes	77	44	7	16	15	7	166

Table 7 Regional distribution of units in England, 1988

	No (%) of district health authorities (n=190)
District handicap team	71 (37)
Assessment centre	54 (28)
District coordinating group	18 (9)
Assessment centre/district coordinating group	25 (13)
Authorities without units	18 (9)
No of authorities that did not reply	4 (2)

CHANGES IN UNITS THAT HAVE TAKEN PLACE SINCE 1983

Among the 146 units identified in 1983 (see table 1) 144 changes had been made by 1988, either in the facilities or in the work done by the unit; these are shown in table 6. This table also shows that by 1988 roughly half the districts that did not have a unit in 1983, and half of those who did not answer our first inquiry, had established a unit of one kind or another; only 24 districts had no such service for their handicapped children.

The changes reported since 1983 were evenly distributed among all types of unit with the exception of district coordinating groups. The most common changes have been an increase in the number of sessions by existing staff, and an increase in the variety of disciplines employed, mainly affecting therapists (60 changes, 42%) and doctors (27 changes, 19%).

Only one third of the units opened during the last five years have been district handicap teams; twice as many have been assessment centres, with or without a district coordinating group. By 1988, therefore, 150 of the 192 district health authorities (78%) had child development centres, of which 71 seemed to be functioning as Court type district handicap teams (table 7).

Discussion

Though it is probably true to say that no two district handicap teams or assessment centres are alike, we believe that the data presented here give a reasonably accurate picture of current national trends. They raise some important questions, and we hope our answers will provoke discussion on the future pattern of centres locally.

In this discussion—as in the introduction—there may seem to be some inconsistency in our use of the terms 'disabled' and 'handicapped'. The World Health Organisation¹¹ has emphasised the distinction between them (with which we agree) but this was made after the publication of the Court report. We have retained the description 'handicapped children' when this has been correct in the historical context though 'disabled children' would be a more exact description using current, accepted terminology.

QUESTIONS ARISING FROM THE INQUIRY

De we need Court type district handicap teams?

In the 10 years between 1973 and 1983 the number of health authorities with special centres

for handicapped children had more than doubled, but barely half of them seemed to be functioning as full district handicap teams. Of the 22 centres established during the last five years of which we have information, only seven can in our opinion be regarded as district handicap teams. Why is this so?

We know that not all doctors like the idea of working in a formally designated multidisciplinary team. Some think it constricting and time consuming; they prefer the traditional pattern of being free to work as independent practitioners making referrals when necessary to specialists in other disciplines with whom they have built up liaisons. Others who are not averse to the multidisciplinary approach maintain that when this becomes formalised into the establishment of recognised teams (as in district handicap teams and child guidance (psychiatric) clinics) there is an unacceptable risk of the ultimate clinical authority and responsibility for the patient's care passing out of the hands of the doctor, with whom (they argue) it should always reside as the most highly trained member of such teams.¹² We are not impressed by either of these objections.

District handicap teams owe their origin to the need for routine multidisciplinary investigation of seriously handicapped children. Responsibility for the whole child, therefore, has to be shared between the professionals assessing the various aspects of the case. Doctors particularly may find this difficult because their training does little to prepare them for the problems that commonly arise in establishing effective interdisciplinary collaboration and decision making.¹³ These problems are seldom insurmountable, and both district handicap teams and child guidance clinics have surely stood the test of time as multidisciplinary units.

We suspect, however, that one of the main reasons why there are not more district handicap teams is because there is a misunderstanding about what they are supposed to do. A number of districts thought that such teams should not have such wide ranging responsibility because (as one doctor put it) 'it needs front line people having the ear of managers' for it to be carried out successfully. Others saw a danger that the district handicap team would be regarded as responsible for the coordination and planning of services for handicapped children, whereas this was the function of a child health care planning team. Some districts said they did not have a district handicap team because they had a team for planning of services for handicapped children, while others admitted that their so called 'district handicap team' had only an administrative function.

This confusion is surprising, as the Court committee quite clearly stated that it deliberately described the second function that it had in mind for the team as operational and not administrative so that it should not be thought that it was implying that a district handicap team should usurp the roles of senior doctors and nurses whose job it was to manage services.

We think that the Court committee's concept of a district handicap team was sound, but as the term itself has clearly proved to be open to

abuse and is therefore redundant we suggest it should be shelved. What alternatives are there? For a number of reasons some units are called assessment centres, but the notion of specialist centres concentrating on assessment was already obsolete in 1974. We can well understand why the Court committee preferred the name 'child development centre' as the base for their district handicap team. Purists might argue that even this is a misnomer because it specialises in disability rather than in development, and disability is not a term that should cause offence as handicap sometimes does.¹⁴ This description is now widely used, however, and it seems sensible for district handicap teams to be referred to in future as child development centres, though such centres must assume both a clinical and operational role.

Where should child development centres be based?

It is logical that the first step in the investigation of a disability in a young child should be a medical diagnosis; it is therefore understandable why in the past health authorities should have taken the initiative in setting up district handicap teams. It is equally sensible for them to be situated in, or within the environs of, the district general hospital where all the necessary specialist medical expertise and facilities are to be found. There are, however, other considerations. The extent to which treatment can be provided depends not only on cooperation among the relevant disciplines but also on having accommodation for them to work in. The inconvenience and often difficulty that parents and children have travelling from a distance may be acceptable for one or two visits for diagnosis and assessment, but would be intolerable for repeated visits for treatment. In addition, facilities that may be appropriate for young children may not be so for older ones. Arrangements for seeing children obviously need to be as flexible as possible, but even flexible services need a base. We think there really is no better base for a child development centre than in the premises of—or adjacent to—the district general hospital.

A separate purpose built centre is the ideal; for most districts this is out of the question but satisfactory accommodation for nursery education and treatment have to be among the priorities. There are four principal ways of making arrangements more flexible, especially for centres that serve more rural populations. Professional staff may examine a child on their own and make their own initial assessment at any place that is convenient for both parties (which might be at home, in a health service clinic, or in hospital); they then meet to discuss their findings and agree on a course of action. Key disciplines may even be able to operate regularly in satellite centres—for example, in clinics or a subsidiary hospital—in which there is sometimes room for a nursery group. In some districts local education authorities provide accommodation for nursery children or even slightly older ones—for example, in an educational psychology unit with a day teaching unit attached and somewhere for the teacher and

visiting staff to confer. Finally, joint examination and assessment (particularly by occupational, speech, and physiotherapists) is gaining clinical favour and obviously has advantages regarding accommodation and staff time.

Some child development centres have special rooms for physiotherapy, others do not, but on our visits we often saw the physiotherapist in the classroom helping the teacher and care staff with the management of children with physical disabilities. Many of them too accepted the need to work mainly through the parents and therefore paid visits to the children's homes. We gained the impression that speech therapists were less inclined to be closetted in the old fashioned speech therapy room that was a feature of the early assessment centres and were more often working in groups or seeing a child and parent or teacher together and discussing ways in which they could all stimulate communication. Unfortunately we asked no questions about Portage schemes but we became aware that many centres were running Portage systems with the mentally handicapped children, and they were doing this in various ways. A Portage system is, of course, carried out in the young child's home; in some centres the psychologist supervised the training of parents and others caring for the child, while in others a health visitor specialising in handicap paid weekly visits to the home.

What age range should child development centres cater for?

In almost a quarter of the districts referral to the child development centres was restricted to preschool children. As the presence of severe disability is usually recognised during the first few years of childhood child development centres understandably have a heavy load of preschool children, but there are still some children in whom serious disability is not diagnosed until after the age of 5. The full investigation of such children, whether they be in ordinary or special schools, should be done by staff at the child development centre, both in the centre and on visits to schools. Such visits are also important in maintaining continuity in the care of children who first attended the centre before they started school; we expect severely disabled children to remain on the centre's register throughout their school years.

The fact that one in four child development centres are open to adolescents is a measure of the long term interest and commitment of paediatricians for handicapped children whom they have known for many years, but it is also a sad commentary on the state of suitable services for this age group. Those who are mentally handicapped can transfer to community mental handicap teams, but child development centres become increasingly inappropriate as a source of health care for physically handicapped teenagers and after leaving school there may be no facilities at all for them.¹⁵ While this situation continues it would be wrong for us to suggest there should be any arbitrary age limit, even of 16, for attendance at a child development centre.

Should child development centres be able to deal with all kinds of disability?

Because of the importance of a multidisciplinary assessment of children who seem to have only one serious or complex (or both) disability, we believe that initial referral to a child development centre is the preferable route to diagnosis and treatment of all disabled children. There are certainly rare disorders for which onward referral to a specialised or regional clinic might be necessary. Most of the less rare but serious disorders, however—even those affecting vision and hearing—can usually be dealt with effectively within a child development centre provided that there is accommodation for, and sessions from, the appropriate specialists. Child development centres can only deal with the 2% or so of children with disorders that give rise to chronic disability—that is, an actual or potential handicap to the child. The children with epilepsy and asthma (amounting to almost 10% of referrals, table 5) may have had extenuating circumstances that required the expertise of the child development centre, but many of them may have been inappropriately referred.

Many of the children attending child development centres in 1983 also had behaviour problems, and helping with difficult behaviour is a major part of a child development centre's work. From our visits we discovered that some children had undoubtedly been referred to child development centres as more likely sources of help in dealing with difficult behaviour than that obtained in a family therapy or an analytically oriented child psychiatric clinic. In other cases the referring doctor had thought that the child development centre was initially the appropriate place because of a strong possibility of organic disease being the cause of the behaviour problem.

Two fifths of children referred to child development centres had learning problems. Does the nature of this disability warrant duplicating or even overlapping facilities between child development centres and community mental handicap teams? We think not. Not all children with learning difficulties are mentally handicapped and referral to a community mental handicap team would not normally be an appropriate way of investigating developmental delay and excluding intellectual retardation; child development centres are well equipped to do this. Furthermore, many of the severely handicapped retarded children have physical or sensory disorders (or both) and need the facilities for diagnosis and treatment that are in or adjacent to most child development centres. We think it is wrong to segregate the investigation and assessment of children likely to be intellectually retarded, or even certain to be (as in Down's syndrome) from those who probably are not; they need paediatric services because of their age rather than mental handicap services because of their disability.

We therefore join Plank in endorsing the Court committee's recommendation that all mentally handicapped children be catered for in the first instance in child development centres.⁹ Only exceptionally should it be necessary for the most severely disabled children to attend a

community mental handicap team, and then mainly for health care. These teams should concentrate on services for adolescents and adults.

We anticipate that 1 to 2% of the children referred become regular clients of a child development centre. There is a further, perhaps similar, proportion of children referred for diagnostic advice and assessment whose disabilities do not prove to be severe enough to warrant regular attendance at the child development centre.

What professional staff does a child development centre need?

If a child development centre is to be able to investigate any kind of severe or complex disability, who are the professionals who need to have regular weekly sessions, and who should visit less often?

There can be no argument about the need for weekly sessions for a social worker and teacher, and we think the need for the teacher has to be emphasised. But what about the therapists? As the Court committee were so convinced of the need to provide and coordinate treatment as well as assessment (and rightly so) it is surprising that it did not name any therapists as core members of the district handicap team. Our data show that in practice about 60% of child development centres regard physiotherapists and speech therapists as core members, and we feel sure that all child development centres should have weekly sessions from them as well as from an occupational therapist.

Doctor, nurse, and psychologist commonly have dual representation in child development centres. Often both the paediatrician and the senior clinical medical officer examine a child; several reasons are given for this (including the fact that the senior clinical medical officer is usually able to do Griffiths's tests), but is it really necessary? We think not. It may of course be a transitional anomaly now that the Court committee's recommendation for the appointment of consultant community paediatricians is slowly being implemented. Having only one key doctor will not, of course, reduce the total number of medical sessions required by a child development centre.

The Court committee also recommended there should be only one kind of clinical community nurse in the child health services with responsibility for both preventive and curative care—a child health visitor; as additional training in the care of handicapped children would be a requirement, some of the them would have already worked in district handicap teams. This recommendation for child health visitors was never accepted by the nursing profession and the choice of nurse for child development centres has been between a nurse and a health visitor, with sometimes both being available. Only two out of five centres have been employing nurses, but in those that did they seem to be indispensable, with more sessions each week than any other discipline. Furthermore, most of the centres that had nurses also had liaison health visitors. It is difficult to imagine how one person could effectively carry out the duties of

both attendant nurse and liaison health visitor, and how some centres managed without either.

It was the hope of the Court committee that the principal psychologist in the core team of five would be a child psychologist with the combined expertise of an educational and clinical psychologist experienced in working with children. Unfortunately this has not happened. We recognise the official role of the educational psychologist in preparing statements for the children needing special education, but the diminishing importance attached to the end point of intelligence testing—especially in children of nursery school age—and the need for more specialist expertise in the management of children with emotional and behavioural difficulties, make the need for weekly sessions from a clinical psychologist the priority if there has to be a choice.

Of the visiting specialists we think there can be no doubt of the need for a limited number of sessions from children's audiologists, ophthalmologists, and orthopaedic surgeons. In 1983 half the child development centres had audiological support (on average three sessions/month) but two thirds had no orthopaedic sessions, and 80% had no help from an ophthalmologist.

The number of child psychiatric sessions was even more unsatisfactory, yet the prevalence of behaviour problems among disabled children certainly justifies frequent visits from a psychiatrist. Only 19% of child development centres had such sessions in 1983 and then on average only two/month.

The current vogue for family therapy does not seem to us to be particularly effective in helping parents to deal with behaviour problems associated with other disabilities; perhaps this is the reason for what one paediatrician described as 'the boomerang syndrome': send such children to the child psychiatrist and they bounce right back. Behavioural approaches seem to have more to offer and in practice we found many of the children being helped by the centre's psychologist. Unfortunately half the child development centres had no sessions from any kind of psychologist and those that did averaged only 1.5 sessions/week. Given the range of tasks they have to undertake this is too few for them to become personally concerned in the treatment of many children. There is clearly a need for child development centres to have more sessions from psychologists and child psychiatrists with special interests in the difficulties of the disabled children present.

Who should refer children to child development centres?

The Court committee appreciated early on that there was a need for parents to be recognised as partners in the process of assessment and decision making, and as front line therapists, in the care of their handicapped children; they therefore stated that parents should have the right of direct access to district handicap teams. This view is not shared by most child development centres today, which (like most specialist services) accept referrals only from doctors.

This is of course a customary privilege that

has its roots in medical etiquette, but it is frequently proclaimed as being 'in the patients' best interests' while conveniently husbanding secondary care resources. We do, however, question both the need for and the ethics of imposing restrictions on parents' access to child development centres, especially as not all the specialist expertise that they dispense is medical. The bogey is often paraded of 'creating a precedent by allowing parents direct access and thus opening the floodgates', but in practice this does not happen and it is unlikely that one in three child development centres would still pursue a policy that led to serious overloading of the service. Most parents do not seem to object to referral only by doctors, and there is much to be said for an initial paediatric opinion being sought about any disability before referral to a child development centre; it does guard against the unnecessary and uneconomical use of scarce resources. Nevertheless, for parents who cannot for one reason or another accept this formality, denial of direct access looks like denial of patients' rights and may put the child at risk.

We believe it is as unwise as it is unnecessary for a child development centre to refuse the occasional direct referral of a child by the parents or by any professional concerned in the care of that child. The ethical, administrative, and practical difficulties it presents can almost invariably be overcome by sympathetic, diplomatic, and sensible handling by centre staff.

Who should fund child development centres?

The government has accepted that district handicap teams should be a multiprofessional service jointly organised and operated by health, education, and social service authorities. Though we know of at least two child development centres that are jointly funded our questionnaire did not ask about funding, only about staffing. One cannot assume that because a child development centre does have sessions from professionals employed by local education and social service authorities they are funded by those authorities, but one can be sure that if it does not the centre is unlikely to be jointly funded. It seems, therefore, that social service authorities are not contributing to the service provided by one third of all child development centres and (more seriously, we think) local education authorities are not contributing to half of them.

The crucial role of health authorities in the early identification and diagnosis of disability is reason enough for health authorities to have taken the initiative in setting up child development centres. On the other hand, local education authorities have had a long standing legal responsibility (strengthened by the Education Act 1981) for ascertaining and meeting the special educational needs of handicapped children from the age of 2. This makes it imperative for professionals in health and education services who see such children to work closely together. It seems to us that local education authorities are under a strong obligation to share in funding the staff and facilities required for the proper assessment and treatment of young handicapped children.

When a disabled child reaches the age of 5 the focal point of service has to shift to the school. From this age at least, health and social services must reciprocate by funding adequately their professionals' sessions in the school. It was disappointing to find that in 1983 only half the districts did this in respect of children who first attended their child development centres in their preschool years; only one in 12 seem to be doing so regularly for other disabled children.

Recommendations

By 1988, only 37% of health districts had what we regard as a district handicap team as described by the Court committee. We think that its concept of such a team was sound, but in future it should be exclusively referred to as a child development centre. Every district should have a child development centre and we highlight its essential features by updating some of the Committee's original recommendations as follows:

(1) The child development centre should be closely associated with the district general hospital but equally committed to providing a peripatetic service in satellite premises (especially in rural areas and in selected schools).

(2) Given this assurance, local education and social service authorities should be prepared to enter into joint arrangements for funding and staffing the child development centre.

(3) The child development centre should initially be able to cater for the needs of all children under 10, and for older children in the absence of adequate, similar facilities for disabled adolescents.

(4) The child development centre should be able to provide initial assessment and treatment for children with any kind of disorder, leaving community mental handicap teams to concentrate on the continuing special needs of mentally handicapped adolescents and adults.

(5) To meet this demand, the child development centre should have regular weekly sessions from a consultant community paediatrician, a liaison health visitor, another nurse, a social worker familiar with the needs of disabled children, a psychologist with expertise in the cognitive assessment of disabled children and the management of emotional and behavioural difficulties, a teacher, a physiotherapist, speech therapist, and an occupational therapist, all of whom should be experienced in working with such children.

(6) The child development centre should also

have at least one session a week from a child psychiatrist and regular (though not necessarily weekly) sessions from children's orthopaedic, ophthalmic, and audiology specialists.

(7) The referral of children to a child development centre should normally be initiated by a general practitioner, a paediatrician, or another medical specialist, but the centre should also adopt the policy of open referral from parents and any professional attending the child.

(8) As well as providing a clinical service, a child development centre should be prepared and equipped to act as a district resource and information centre for disabled children, and to contribute to the inservice training of all professionals in the district who may play a part in the care of disabled children.

(9) The child development centre should take part in the district's epidemiological studies relating to disabled children and help to monitor the service it provides.

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