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Abstract

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PSYCHIATRIC SERVICES FOR CHILDREN

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Thus, in a recent report based on information obtained from paediatric units throughout the United Kingdom, the facilities available to adolescents who had left school were said to be in almost every case simply the general paediatric and adult mental services. For children of school age, both In- and Out-Patient psychiatric services were said to be very inadequate. Regarding in-patient treatment, psychiatrists are very often compelled to make use of beds in general paediatric departments. The waiting period for an out-patient appointment can be very long—in one extreme case, 2½ years. No information was available in the report regarding the facilities for children of pre-school age.

Such psychiatric services as do exist are established either by the Local Authority or as a unit within the National Health Service. Only about 2/3 of Local Authorities run any form of Child Guidance Service. Regarding England and Wales, and with a view to the treatment of maladjusted children within the educational system, it was recommended in 1955 by the Underwood Committee that the Local Authority should provide the premises, the educational psychologist and the psychiatric social worker, while the Regional Hospital Board supplied the psychiatrist. Whether or not child psychiatric services should be run along such lines is a question still not fully settled.

Both in the case of the Child Guidance Clinics run by the Local Authority and the school medical service run by the Education Department of the Local Authority, the psychiatrist is available almost invariably only on a part-time basis, or for consultation in the case of particular children. In either case, the psychiatrist is made available by the Regional Hospital Board. In Scotland, there are now seven full-time consultant child psychiatrists.

The position of the psychiatrist in relation to the juvenile offender is likewise barely satisfactory. Certainly in a large proportion of cases, repeated offences are essentially manifestations of reactions to psychologically disturbing situations, and must where possible be distinguished from true mental

illness. In the former type of case, the stable environment and the modified type of education available in an approved school may be adequate to restore the child. At any rate, information about the child's background is supplied to the juvenile court by the Education Authority and the probation service—often at short notice. A psychiatric opinion, should the court deem it necessary, is made available through the Child Guidance Service.

Out of every 5 approved schools in England and Wales, 3 have the services of a psychiatrist from the Regional Hospital Board, who may visit for regular sessions. Where that is not possible, a psychiatric opinion, if thought necessary, can usually be obtained at an outside clinic. A recent Home Office report speaks of the suggestions and the unobtrusive contribution of the visiting psychiatrist, the Headmaster retaining all executive authority. On the other hand, in a few cases psychiatric social workers have been appointed and work in close conjunction with the visiting psychiatrist and Headmaster. In Scotland at present, there is probably no instance of any contractual relationship between an approved school and the child psychiatrist. Instead, the frequency with which psychiatric opinion is requested depends upon the sympathy of the Headmaster to the psychiatric approach and the availability of a child psychiatrist. The arrangement, in fact, works quite well, but will probably become more formalised in the near future.

The juvenile court is also empowered to recommend a course of psychological treatment at a Child Guidance or psychiatric clinic, presumably where such is available. The Local Authority can send the child, on psychiatric advice, to a residential school for maladjusted children. Such schools are however, very few, as are the special Day Schools set up by a few Local Authorities, and unable to cope fully with the problem. At such schools, psychotherapy is sometimes available.

The situation shows slight improvement. For children requiring special medical investigation and treatment, there are now 8 children's psychiatric units in Scotland. These, understandably, should be no more concerned with investigation and diagnosis than with long-term treatment, but due to lack of accommodation in their premises, long-term treatment must very often be continued in less specialised departments or in schools for maladjusted children. Several children's psychiatric units have recently been opened—for instance, in 1959 the male adolescent unit with 16 beds at the St. Augustine's Hospital in Kent. But even regardless of facilities, the supply of staff is a major problem, for both nurses and psychiatrists require training in the handling of the specialised psychiatric problems of childhood and adolescence.

THE COMMON COLD

Over the last ten years or so there has been considerable interest in this ailment. Though the symptoms of this infection are not particularly severe, it is of considerable economic importance. It has been calculated that in one year over twenty million man working-hours were lost solely as a result of the common cold.

In 1946 it was suggested that the cause was a filterable multiplying body. Attempts at cultivating the organism and testing for its presence in vitro were unsuccessful and studies had to be carried out on human volunteers. In 1953 at Salisbury it was reported that an organism, retaining infectivity in human

volunteers, had survived ten passages through human embryonic lung tissue culture maintained in medium 199. Attempts to repeat this experiment failed. Since 1956 a number of organisms causing minor respiratory ailments have been isolated in the United States. These viruses were found to be related to the Cox-sackie and ECHO sub-groups of the entero-viruses and certain myxo-viruses that were finally classified under the names of para-influenza 1, 2 and 3. These viruses were studied at the Common Cold research unit at Salisbury and it was concluded that though they could cause the common cold in children they were not the principle actiological agent.

The Salisbury unit maintained that the commonest form of the common cold was typified by an increase in nasal discharge (measured by the number of paper handkerchiefs used by the infected volunteers), a sore throat, particularly at onset, and a cough. Usually the patients were afebrile. In 1960 Tyrrell reported that an organism producing typical symptoms of a common cold had survived a number of passages through human embryonic kidney tissue culture maintained in 199 medium supplemented by the addition of bovine plasma albumin and maintained at 33°C at an acid pH. The culture was well oxygenated using rollers. Since then three strains have been identified and cultured but there are probably many other, as yet uncultivated, causative strains. When the virus was cultivated cytopathic changes were observed in the cells of the culture medium. The cells became refractile and later dropped away from the glass of the container. These changes were not observed in control cultures or when the inoculating fluid had been heated to 56°C or maintained at a pH of 2. It has been found that cultures infected with common cold viruses gives rise to interference in the growth of influenza virus when subsequently inoculated onto the tissue culture. A quantitative estimate of interference, and hence of the growth of the common cold virus can be made by determining the amount of haemadsorption of human red cells onto the tissue culture cells infected with the challenging influenza virus.

The multiplicity of infecting organisms presents a poor picture as far as prophylactic immunisation is concerned. Claims of cross immunity between various strains have not been proved. However it is hoped that some non-specific antiviral substance such as interferon may be developed. Another possibility in prophylaxis is that study of the epidemiological characteristics of the viruses may enable methods to be developed that will limit spread of infection.

NORMALITY

its cause and cure

For many centuries mankind has sought to define normality objectively, and if all the men and women who have tried were laid lengthwise, heel to head, I should be found at the end of the line, flat out. All societies have their misfits, but the causes of normality in any one community are multiple. Societies have a code of behaviour to which its members are expected to conform but, just as this varies from one society to another, so do the permitted degrees of deviation from the code and the methods used to bring the misfits back into line. Divergencies are reflected in the marital status for, somewhere and at sometime, practically every imaginable pattern of marriage

has been regarded as proper. Toleration of deviation from the social norm seems to evolve with technical development. In officially Christian, monarchical, monogamous Britain, for example, you can profess any religion or none, drink to excess or remain "dry", refuse military service, practise successive (but not simultaneous) polygamy, speak in derogatory terms of the Government, the Church and the Monarchy, and, short of actual nudity or what is technically known as exposure, indulge in any eccentricity of dress. If you are a woman with homosexual desires the law will be little concerned with your behaviour because homosexual practices among women seem never to have been regarded as constituting a social danger and occur for the most part between consenting adults. If you are a man, however, your homosexual relationships with consenting adults in private may lead to imprisonment and social disgrace while promiscuous heterosexual intercourse will not receive legal distinction. Accepted behaviour changes in the same society as time passes, and it has been said that if you go into a room nowadays and see people smoking and wearing trousers they are more likely to be women.

I should admit, as *a priori* justifiable, the right of a community to interfere with its members in order to secure the biological necessities for all, but, I cannot admit its right to interfere in matters where one man's possessions are not obtained at the expense of another e.g. opinion, knowledge, and art. The fact that the majority of the community dislikes an opinion gives it no right to interfere with those who hold it. The same argument applies to interferences with personal morals. But, it seems, that tolerance only grows where fear declines. For centuries intolerance has been the result of man-made fear and has restricted the potential variety of human experience. Only when man has become master of himself as well as his **environment** can he afford the luxury and enjoyment of tolerance.

Contemporary society is coming to regard antisocial behaviour as a symptom of mental abnormality and appoints the doctor to administer not the treatment the patient "deserves" but the one he thinks most likely to effect a cure. But by what thread of dignity does normality hang? Should we not ask ourselves if our society is adapted to its individuals? Freedom is not the right to oppress others but the right to live as we choose and think as we choose when our actions do not prevent others from doing likewise. Dr. Eliot Slater has presented us with evidence which suggests that there is a small proportion of the population which is so constituted, perhaps in large part by genetical causes, as to be unable to form normal heterosexual relationships and to be strongly predisposed to homosexual ones. Professor Penrose suggests that variations in sexual polarity might be regarded as a perfectly normal trait, comparable with variations in stature, hair pigmentation, handedness, or visual refractive error. These traits are all probably dependent upon interaction between heredity and environment and the variation within all of them is probably of degree rather than kind.

"An important object of medical treatment of a homosexual person is to help him to reach a stage where he is able to exercise sustained restraint from overt acts which would bring him into conflict with the law. It will also help him to achieve self-discipline. This will lead to increasing *self respect* and enable him to feel he "belongs" to a society which does not condemn him outright." Hormone treatment undoubtedly diminishes libido and relieves patients from the anxiety by giving them the feeling that they can control their urges but should we prescribe a pill to bring the body into line with socially acceptable morality? Can we justify the use of a drug which eliminates an effect when you have not eliminated the desire that causes the effect? It depends upon what sort of society you want to live in.