



# The Newsletter



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Margaret Bamforth	Child & Family Public Education Board
Peter Gallagher	Northern Irish Division
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Sabrina Hibbert	SAS
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## **Editors column**

Welcome to the Autumn Edition of the Faculty Newsletter!

After a fantastic residential conference in Liverpool it is now time to start looking forward to Christmas and planning our New Years resolutions for 2009 (I may just have to carry over my 2008 list...!)

Have a fantastic Autumn and Christmas period and see you next in the new year!

**Kay Harvey**

## **In this issue...**

We have updates from the Executive in The Chair's report from Greg Richardson...and on CAPFECC from Brian Jacobs.

We have the winning medical student essay prize from Alicia Khan and a report from the new trainee representative, Jo Barker.

We also have information about all the prizes offered by the C&A Faculty....information about NWW in CAMHS....feedback from the National CAMHS review and dates for the diary...

Finally an invite to report cases of Conversion disorders...and to join QINMAC.

## The Chair's Column

**Greg Richardson**

I write as I return from our annual residential meeting, or at least I did before I fell asleep on the train, victim of too much enjoyment at the Conference Dinner in the glorious splendour of the Adelphi Hotel in the ever vibrant City of Liverpool; totally unphased by being City of Culture, the drunks and ladies of Lime Street were as friendly as ever. Emily Simonoff did a great job with the academic programme, which kept people entranced for the two and a half days, ably supported by the conference office, who worked hard at meeting our every whim. Our attendance was about the same as last year, so we still aren't meeting non UK numbers, I wonder how we will fare in Dublin next year? I wonder if people are having more trouble getting study leave or clinical responsibilities prevent attendance. Or maybe training in people's local areas fulfils their CPD requirements. I always put "keeping up to date" on my annual PDP, ensure it is in my appraisal, and that justifies my attendance.

I was distressed to hear of a number of services that are being mismanaged and CAMHS staff bullied by managers who are totally ignorant of the mental health needs of children and young people, especially when they have mental disorders. Demands to justify your service or submit complex tenders are jobs for managers, but unfortunately they can't do it without clinical input, although some do try. This takes up clinical time making less available for the children and young families on our patch, although this is not recognised by the related throughput monitors! Fortunately I think most of us are managed well by managers who recognise the gaps in their knowledge as

well as their strengths, but I have just written to one Strategic Health Authority chair as managers within one of their foundation trusts clearly don't have any understanding of clinical governance in CAMHS. I am not going to champion individual grievances, but if a service is consistently mismanaged to the detriment of children and families involved with CAMHS please let me know and give me the details and we will see what we can do to prevent the service for those young people being damaged further.

I had a bit of a rant about the tiers at the Annual Business meeting as there seems to be a belief developing that all "core", "specialist", "comprehensive" or "community" CAMHS is based at tier 3 and if in-patient care is involved its tier 4. I don't know where this bastardisation of the strategic approach used in "Together we Stand" (NHS Health advisory Service, 1995), which was developed to help people understand the complexities of CAMHS, but it is leading to our services again not being well understood. Core, specialist or community CAMHS operate at tiers 2 and 3; tier 2 when a CAMHS professional is working on their own, e.g. when providing consultation to an organisation or working with a child with ADHD and their family where there is not an attentional problems team in the CAMHS. A CAMHS professional who cannot work on their own at tier 2 clearly has had insufficient training or experience and is not good value for money in the team. Tier 3 is specialist teams so a CAMHS may have a consultation team where different members work with different parts of an organisation but have a team perspective. Similarly a tier 3 attentional problems team within a CAMHS will have different CAMHS professionals working with different parts of the system with which the child is involved. There are currently a lot of initiatives at tier 1, such as SEAL, parenting programmes as well as foster

care, directed at improving the mental health and emotional well being of the child population and these are to be welcomed as preventive measures to improve children's mental health. Generally they do not depend on CAMHS professionals for their everyday operation but probably use them for support, training, consultation and sometimes direct input. The CAMHS professionals are not working at tier 1, they are supporting tier 1, so a tier 3 Looked After Children's Team, which may include social workers may support field social workers at tier 1. If there is any confusion please go back to the original documentation, which the government ratified as the way to understand CAMHS. End of rant!

I do hope you have an enjoyable and productive autumn

**Greg Richardson**  
**Chair of Child and Adolescent Faculty**

## **CAPFECC update**

**Brian Jacobs**

CAPFECC has now sent out a draft curriculum to all Training Programme Directors (TPD's), dated 15<sup>th</sup> September 2008. We have asked them to share this with all trainers and ST4-6 trainees. If you have not had it then please contact your TPD. It is not yet officially approved by PMETB but is in the process of being examined by them. Their initial response was very positive but they may want changes still. Remember that you will need to look at the core curriculum for relationships with colleagues, health and probity. These are not particular to Child and Adolescent Psychiatry, so we have left them out of our curriculum.

Flowing from this piece of work, we need feedback from schemes about the usefulness of the curriculum in its present form. We will survey schemes more formally in a few months but in the meantime we would be grateful for your thoughts. If you have access to user or carer groups, we would also like their views. We have to develop forms to allow you all to record trainee progress during the year and two higher trainees have offered to help with this. If others have ideas about how best to do this, I am very open to considering all suggestions. One of the challenges is that partial evidence will come from many trainer-trainee interactions as well as workplace based assessments. How do we ask you to summarise these without it becoming very complex, so that accumulating evidence can be recorded that adds up to competency achievement?

I have had to concede a change in the requirement for a six month placement in Child and Adolescent Psychiatry at CT1-3. At present, this is not necessary to take membership but it is a requirement to join the College. This has been leading to some difficulties for competent trainees. It is now becoming a larger issue for the College as they are starting to run membership exams in Hong Kong and want to market College membership more widely. In future, to take the CASC exam (the final part of the membership exam) candidates will have to provide evidence that they have the curriculum competencies in Child and Adolescent Psychiatry. I have had the Dean agreement that this must be signed off by a consultant child and adolescent psychiatrist. This carries some risk only if our colleagues are insufficiently careful about checking that the trainee has actually had the experience that will enable them to get the competencies. We have delineated the required competencies in our curriculum.

Finally, I want to remind those TPD's who have not applied for the Faculty grant of up to £1000 that it exists to support them in improving their training schemes. So far only about 25% of schemes have contacted me. All you need to do is to email me to be sent a simple application form. If you have any queries, please contact me.

**Brian Jacobs**  
Chair of CAPFECC  
[b.jacobs@iop.kcl.ac.uk](mailto:b.jacobs@iop.kcl.ac.uk)

### Prizes awarded at the Annual Residential Conference 2008

#### Emily Simonoff

The winner of the Margaret Davenport prize for the best oral or poster presentation by a Specialist Registrar is Dr Holan Liang who spoke on "Risk Factors for ADHD in Children with Learning Difficulties".

The Programme Committee noted the number of high quality submissions by Specialist Registrars and wish to extend congratulations, not only to Dr Liang but also Dr Toby Zindel, Dr Dennis Ougrin, Dr Mar Vila, Dr M. Ramirez and Dr Ruth Norton for excellent presentations.

The Medical Student Essay Prize was won by Alicia Khan from London and the winning essay is printed later in this newsletter. Congratulations Alicia and good luck in your foundation training!

Congratulations should also go to Beth Lynch, a final year Liverpool medical student, who presented extremely confidently on the final day of the conference. (the Editor)

**Emily Simonoff**

#### Academic Secretary

### A reminder of Prizes available from the Child and Adolescent Faculty...

#### Kay Harvey

This is just to remind everybody of the prizes that are available from the Faculty. Further details about each of the prizes and how to apply can be found on the College website ([www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)). It is worth paying particular attention to the Gillian Page Prize which is biennial and next awarded in 2009.

Please encourage any trainees or medical students you have to participate.

On behalf of the Faculty I would like to thank the families of Gillian Page and Dr Margaret Davenport for their continued support.

#### The Child and Adolescent Faculty Poster Prize (annual)

ST1-3's in any discipline are eligible to apply. The prize is £300 and the prizewinner will be invited to the annual residential meeting, and the costs of travel, accommodation and an invitation to the conference dinner will be covered by the Faculty. The closing date for entries is 18<sup>th</sup> Feb each year.

#### The Gillian Page Prize 2009 (biennial)

Specialty trainees ST1-6 are eligible. The prize may take the form of a research project, a review of a particular topic or a study of some clinical innovation. A project involving collaboration between workers, whether psychiatrists or in any other discipline, may be submitted, but the prize may be shared between no more than two eligible psychiatrists. The prize is £500. The deadlines are as follows, for

the title and short protocol; end of January 2009 and then for essay documents; end of April 2009

### **The Margaret Davenport Poster Prize (annual)**

SpRs/specialty trainees STs 4–6 or newly appointed consultants in child and adolescent psychiatry (including those on joint faculty training programmes with other faculties) as well as those who are within six months of having obtained their CCT by 18<sup>th</sup> April of the year in which the residential meeting occurs are eligible to apply. The prize is £100 and the winner will be included as a guest at the Faculty annual residential meeting and conference dinner. The conference fee will be waived. Allowable costs for travel and accommodation will also be reimbursed retrospectively. The closing date for entries is 18<sup>th</sup> Feb each year.

### **The Medical Student Essay Prize in Child and Adolescent Mental Health (annual)**

Eligible to 4<sup>th</sup> and 5<sup>th</sup> year medical students in the UK and Ireland. The prize is £500 and the winner will be included as a guest at the Faculty annual residential meeting, and the conference fee will be waived. Accommodation and an invitation to the conference dinner will be additional to the prize, in the form of a bursary of up to £200. The closing date is the end of Feb each year.

### **Bursaries for developing countries (annual)**

In September 2002 the Faculty of Child and Adolescent Psychiatry undertook to establish annual bursaries to enable delegates from developing countries to benefit from attendance at the Faculty's residential meeting. The bursaries are intended to cover the cost of economy class travel, accommodation, free registration and attendance at the conference dinner. Informal mentors will be identified for each candidate to

enhance their introduction to Faculty members and their enjoyment of the meeting.

A cheque up to a maximum of £1000 will be provided to each successful candidate on presentation of original tickets and receipts for all related expenditure, together with a completed non-members' expenses claim form. Five bursaries up to a maximum of £1000 each will be funded each year. The closing date is April each year.

**Kay Harvey**  
The Editor

### **The Medical Student Essay Prize, 2008 Winner.**

**Alicia Khan**

### **The Future Role of the Doctor in Promoting Child Health**

#### **Introduction**

As part of the government's Every Child Matters initiative, a review has been set up to look into " how well services are meeting the educational, health and social needs of children and young people at risk of, and experiencing, mental health problems."<sup>1</sup> This will be published in November 2008 and will provide an assessment of all services involved in the welfare of children, not just those related to child and adolescent mental health. In this essay I shall be considering the role of the doctor, both within a CAMHS team and in other areas of healthcare, as part of the broader services offered to children with mental health problems by a multidisciplinary team of professionals. I

<sup>1</sup>Children and Adolescent Mental Health Services Review2008<http://www.dcsf.gov.uk/CAMHSreview/>

shall also discuss the issue of promoting good mental health in children, since it is as important to protect mental health and prevent any deterioration early on as it is to diagnose problems when they present<sup>2</sup>. The issue of social attitudes towards child psychiatry, and current stigma around diagnosis and medication will also be addressed. In order to relate this theme to a real case, I shall be discussing the different issues raised by the title within the context of one particular case that presented as a new assessment to a Tier 3 CAMHS service, and in whose assessment I played an active role.

In the first part of the essay, I present different aspects of the case study, and in discussing them, refer also to wider issues in current practice. In the second part, I identify a number of key issues relating to current and future practice in relation to child mental health, and examine them more broadly, whilst sometimes making reference again to the case study.

### **The Case Study**

Firstly, let us consider the case of H:

#### **Case Summary**

*H is a 10 year old boy who has suffered from problems with anger control for many years. The triggers for these frequent outbursts are linked to his rigid behaviour and strict routines. These routines have been followed by the family, ultimately allowing H to control his environment, and any attempt to change them will result in anger. He also needs to be the centre of attention and feels frustrated and angry when his sister is the focus of attention. His relationship with his mother is mixed, as she is often the recipient of his violent behaviour, but he is also desperate for her affection and reassurance following an outburst of anger. H is less likely to*

<sup>2</sup> Longley M, Williams R, Furnish S, Warner M (2001). Promoting mental health in a civil society: towards a strategic approach. London: The Nuffield Trust

*behave aggressively around his father, whom he stays with every other weekend and on Wednesdays after school. H suffers from both motor and vocal tics which have also been a problem for a long time, and he has not received any form of intervention for these so far. His social skills are affected, and he has never had any close friends at school, often being controlling when playing games with others. At school, however, his behaviour is reported to be very different to that seen by his parents. H's mood can be labile, ranging from extreme joy to very low, but he has talked about different methods of killing himself recently to his mother, who is very concerned about this. H has always eaten a lot, and is currently overweight for his age and height. His mother feels that she may no longer be able to cope with H whose behaviour has had a huge impact on her life, both in terms of her failed marriage and also resulting in the loss of all her friends in the village.*

In order to make a full assessment of this child's needs, it is important to consider all aspects of the presentation using both a medical and a social model of mental health, involving different members of the MDT to achieve this. A medical model approaches mental health from a more traditionally biological approach, considering potential genetic or biochemical changes within the brain, whereas a social model considers the problem as part of a wider cultural and social construct<sup>3</sup>. As H's problems have an impact at an individual level, but as also within his family system and beyond to the outside world, I shall be considering each of these areas in turn.

#### **Diagnosing H**

<sup>3</sup> Rutter M, Taylor E, Hersov L (1994) Child and Adolescent Psychiatry: Modern Approaches. Blackwell

Before going into more detail about H's behavioural problems, it is relevant to note the referral pathway that led him to the specialist clinic. Initially his GP was involved in referring him to a community paediatrician when he was only 3 years of age, recognising that he was displaying unusually challenging behaviours. The paediatrician assessed him and diagnosed Asperger's Syndrome, recommending certain behavioural interventions and specific management. However, unhappy with this diagnosis, his parents then saw a child psychiatrist privately who disagreed with the initial diagnosis and instead suggested "explosive child pattern behaviour". The parents were happier with this label, but later had to return to the NHS system, having employed little active treatment or management.

I shall discuss certain aspects of the diagnosis later on, but it is interesting here to note how doctors at every step of the pathway were involved. It highlights how important it is for GPs, at a Tier 1 level, to be able to recognise potential mental health problems and refer appropriately. This is an important part of promotion of child mental health, as prevention or early intervention can have very positive outcomes at this stage, even though early recognition at Tier 1 is not yet optimal<sup>4</sup>. This raises the issue of providing education and consultation from specialists to other doctors and mental health professionals as an important role for child and adolescent psychiatrists to provide in the future, since according to one paper only 2% of specialist time is currently used for this purpose<sup>5</sup>. Nevertheless, screening tools such as the

Strengths and Difficulties Questionnaire<sup>6</sup> can be used when there is a suspicion that a more detailed assessment may be required, allowing more confident early intervention and recognition.

It could be argued that the role of the doctor, as opposed to other professionals involved in the MDT, is to be able to diagnose, using the criteria provided by ICD10 or DSM IV, and offer appropriate management with the possibility of pharmacotherapy if required. In this case, as with many others, there is not one clear unifying diagnosis within the set criteria. A more detailed consideration of H's rigidity may be useful:

*H has several rigid routines. When he was 4 years old his father recalls that if a fork on the table was out of place he would "explode"*

*Dressing: H has always had to follow a specific routine when getting dressed. He has to have all his clothes laid out on the bed. He will then proceed to rub each item on his face to ascertain whether it is soft enough, will smell them and try them on. He will usually reject the first few. This will be repeated with each item of clothing until he is dressed. He does not like to mix colours of clothes in his wardrobe.*

*Toileting: H, once dressed, will often need to go to the toilet, but will only sit on the seat when completely naked. He will therefore have to undress again. He always spends at least 40 minutes on the toilet.*

*School Route: H will become very agitated and eventually physically aggressive if his mother ever deviates from the normal route to school in the car.*

H's rigid behaviour, his lack of friends or ability to socialise with peers effectively, his multiple motor and vocal tics and his inability to control his anger all tend to

<sup>4</sup> Royal College of Psychiatrists (2002). Prevention. London: Royal College of Psychiatrists

<sup>5</sup> Payne H, Butler I. Promoting the mental health of children in need. 2003 Department for Education and Skills, Making Research Count

<sup>6</sup> Goodman R, Scott S. Comparing the SDQ and the CBCL: is small beautiful? J Abnorm Child Psychology 1999; 27 (1): 17-24

suggest a neurodevelopmental cause for his problems. A diagnosis of Asperger's Syndrome, in view of the fact that his language development was if anything precocious rather than delayed, might be the most obvious first suggestion as offered by the community paediatrician. However it could be argued that he fits the criteria for several diagnoses including Tourette's disorder with explosive outbursts<sup>7</sup>, as well as a mood disorder such as depression. While it may be argued that the phenomenon of comorbidity is an ever increasing feature in the current diagnostic system<sup>8</sup>, it can also be an important way to promote better mental health by addressing each individual problem appropriately and within the broader context of the child as a whole.

The alternative description of H's behaviour, that of "explosive child pattern behaviour", is not an official ICD10 or DSM IV diagnosis. However, the description below does seem to fit well with our case:

"there is high activity level, distractibility, high intensity, withdrawal or poor reaction to new or unfamiliar things, poor adaptability (reacting badly to changes in routine), negative persistence (strong willed, whiny, rigid) low sensory threshold (for example clothes that don't "feel" right), and negative mood (cranky, irritable)."<sup>9</sup>

This raises another important point as regards the future role of the doctor in this area. Currently, the classification and aetiology of many psychiatric problems is

<sup>7</sup> Budman CL, Bruun RD, Park KS, Lesser M, Olson M. Explosive outbursts in children with Tourette's disorder. *J Am Acad Child Adolesc Psychiatry*. 2000 Oct;39(10):1270-6

<sup>8</sup> Tew J, Pincus H. The Conundrum of Psychiatric Comorbidity. Dec 2007 Vol. 24 No. 14. *Psychiatric Times*

<sup>9</sup> Greene, R W. *The Explosive Child*. 1999 HarperCollins.

unclear, with much research being undertaken in order to gain a greater understanding. The fact that many children seem to fit into several diagnostic categories, as mentioned above, suggests that the boundaries distinguishing each individual diagnosis are not always well defined, nor indeed should they be. Whether H is to be labelled as atypical Asperger's or an explosive child or something else, it is clear that the current system of classification will always need updating or adapting to newly discovered clusters of signs, symptoms and behaviours. Certainly with increasing knowledge about the brain's structure, function, biochemistry and neurodevelopment, future research will prove invaluable to furthering the knowledge base of fields such as child mental health.

### H's Family

The impact of H's behaviour has had a very detrimental effect on the family unit. Although H still sees both parents, they finally divorced a year ago, marking a noticeable deterioration in his behaviour and prompting the referral. Immediately this highlights the importance of understanding a child's position within the family system, as it will have a huge impact on any child's behaviour if there is any disruption. In H's case, since we have seen one of his major triggers for aggression is any change at all, his current family situation is clearly a central factor in the problems he is facing. Furthermore, the presence of marital disharmony has been shown to negatively impact on a child's adjustment and emotional security<sup>10</sup>.

<sup>10</sup> Du Rocher Schudlich TD, Cummings EM. Parental dysphoria and children's adjustment: marital conflict styles, children's emotional security, and parenting as mediators of risk. *J Abnorm Child Psychol*. 2007 Aug;35(4):627-39

H's mother states that she feels H was partly responsible for the divorce. She has a difficult relationship with him, and is completely unable to control his anger apart from adapting to his needs exactly. H, consequently, displays extreme physical and verbal aggression towards her when angry, recently stating "you are a dried up old ovary, nobody wants you". However, he is clearly attached to her as well, and will become extremely remorseful and needy of affection and reassurance following an outburst. With his father he is better behaved, especially when they are alone. Interestingly, his father was much more critical of him during the assessment, calling him "a wimp" as regards pain, and noting that although he enjoys sport he is not good at anything.

This latter point raises the importance of promoting good self-esteem in children as part of a preventative method of protecting good mental health. It is argued that this promotes resilience<sup>11</sup>, which can enable children to deal with life more successfully, thus mediating against any other risk factors they may have. A child's self-esteem is in part due to the security of their early attachment to their parents, and the confidence that they are valued and loved. In the case of H, although his parents were clearly concerned for the wellbeing of their son, the various tensions and accusations noted may well be affecting his sense of self-worth. As we shall discuss later on, this may be further compounded by his lack of friends, and his inability to deal with life's challenges successfully.

H also has two siblings, one half sister who is 22 years old, and one younger sister aged 8, neither of whom suffer from any physical or psychiatric conditions.

<sup>11</sup> Rutter M (2000) An update on resilience: conceptual considerations and empirical findings. In J Shonkoff (ed) Handbook of early childhood interventions. Cambridge University Press

The younger sister is the focus for much of H's anger, and is often the recipient of his violence. H appears to be very jealous of any attention she receives, possibly suggesting further insecurity as to his position within the family. However, H has a good relationship with his older sister, although she is no longer living at home. Again, this highlights the need to consider all aspects of a child's home environment, as his younger sister may be a trigger, and his older sister an important promoter of H's self-esteem and therefore resilience.

The importance of using interventions that also consider the child as part of the family system rather than as a lone individual is crucial<sup>12</sup>, and it is the role of the doctor involved in a child's care to liaise appropriately with specialist services that can provide this care. While many CAMHS teams will be able to offer family therapy, there are also other organisations that may offer additional support groups, parenting courses and education. It is therefore essential for doctors to be aware of all of these services so that they can make sure each family has access to optimal care. Training in parenting skills, as well as problem specific focused courses have been shown to have positive long-term results<sup>13</sup>. Furthermore, it is important for doctors to educate parents about the mental health problem that their child is facing in order to ensure engagement with the treatment plan and specialist team<sup>14</sup>.

<sup>12</sup> Fonagy P Target M Cottrell D Phillips J Kurtz Z (2000). A review of the outcomes of all treatments of psychiatric disorder in childhood: Final report to the NHS executive

<sup>13</sup> Hemphill S A, Littlefield L. Evaluation of a short-term group therapy program for children with behaviour problems and their parents. Behav Res Ther 2001 Jul; 39: 823-41

<sup>14</sup> Zwaanswijk M, van der Ende J, Verhaak PF, Bensing JM, Verhulst FC. Help-seeking for child psychopathology: pathways to informal and professional services in the Netherlands. J Am Acad Child Adolesc Psychiatry. 2005 Dec;44(12):1292-300

## H's School

Interestingly, H has not had any particularly bad reports from school, either in terms of his behaviour or academically. Indeed his father stated that the report would paint a contradictory picture of H compared to the one they would describe. For many children with mental health problems, school can present a big challenge both for the child and for the teachers. In this respect, it is crucial for doctors to establish a liaison with the school of the child in question, both in order to gain useful information that can contribute to the assessment and diagnosis, but also to provide the school with suggestions about possible management strategies<sup>15</sup>. Furthermore, for children with ADHD, it is essential to know that a child's behaviours are similar whether they are at home or at school before making a diagnosis. Often, it can therefore be useful to include a school observation as part of a child's assessment, performed either by a psychiatrist or a psychologist. In the case of H, the fact that he does not exhibit the same behaviours at school may not necessarily be surprising, as we already know that he can behave differently with different parents. Indeed, the structure and routine offered by certain classrooms might even appeal to his preference for following familiar routines. Naturally, many children with an Autistic Spectrum Disorder may struggle in a mainstream school which does not cater for their many and varied needs, but will often adapt better to a specialist school that is expert at managing certain behaviours and offering adaptations to communication or language difficulties such as the use of

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<sup>15</sup> Williford AP, Shelton TL. Using mental health consultation to decrease disruptive behaviors in preschoolers: adapting an empirically-supported intervention. *J Child Psychol Psychiatry*. 2008 Feb;49(2):191-200

Picture Exchange Communication System (PECS) or sign language.

As we mentioned earlier, self-esteem is an important protective factor for any child, especially for those with mental health problems. Success in school is another crucial element to developing this, and it is therefore vital to assess whether a child is able to attain his educational needs from his or her current school. For H, who attends an independent school, this appears to be a positive feature in his life, as he is achieving quite well academically.

Socially, however, school is not such a success. H does not have any friends, which may have an impact on his low mood. It is important to consider this aspect of school for H, as, ironically, there is a risk that his emotional needs will not be recognised by school if he is not disruptive and is managing academically. Indeed, although this is not the case for H, it has been estimated that only 10% of children with mental health problems are under the care of specialist services, and many of these will be those with behavioural or conduct disorders, rather than depression or another problem less challenging or burdensome to those around them<sup>16</sup>. Again, this is an important issue to consider when looking at the future role of doctors in child mental health. An awareness of the above fact may mean that any doctor who comes into contact with a child who may be suffering quietly, will hopefully recognise and refer appropriately.

H's case represents the need to view each child as an individual and within the context of his environment. He is still undergoing further assessment, including psychological evaluations, and as yet has not received an official diagnosis.

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<sup>16</sup> Rawlinson S, Williams R (2000). The primary-secondary interface in CAMHS – burden as a defining feature. *Current Opinion in Psychiatry*, 13: 389-395

## **The broader picture: future roles**

### A medical approach

As we have mentioned earlier, the role of the doctor within child mental health is broad. Whilst it may be clear that a paediatrician is responsible for the physical well-being of a child, and a child psychiatrist responsible for their psychological health, the boundaries between the two are not precise. There is clearly an important role as regards early recognition for community paediatricians presented with children displaying developmental delay or behavioural problems. It has been suggested that further specific training models for paediatricians focusing on child mental health problems can increase the rate of recognition, diagnosis and appropriate treatment or referral<sup>17</sup>. This will be a useful step forwards, hopefully enhancing the communication and links established between paediatricians and psychiatrists, which should consequently mean that more children will receive the appropriate care.

Similarly, it is important to recognise the links between many medical conditions and psychiatric comorbidities. The roles of paediatric geneticists, neurologists, haematologists and even endocrinologists are also central to many children suffering from physical and psychiatric conditions. It is therefore necessary for both physicians and psychiatrists to be aware of the potential risk factors that certain physical conditions can entail. For instance, the high risk of depression and eating disorders in young people suffering with diabetes is well recognised<sup>18</sup>, and it is

<sup>17</sup> Goodfriend M, Bryant T 3rd, Livingood W, Goldhagen J. A model for training pediatricians to expand mental health services in the community practice setting. *Clin Pediatr (Phila)*. 2006 Sep;45(7):649-54.

<sup>18</sup> Grylli V, Hafferl-Gattermayer A, Wagner G, Schober E, Karwautz A. Eating disorders and eating problems

therefore important for paediatricians reviewing their diabetic patients to look out for warning signs and respond accordingly. Similarly, a child presenting with, for instance, a chronic headache, must be investigated appropriately for all potential physical causes, yet if none are found, a psychiatric referral may be appropriate.

As more is understood about the aetiology of some neurodevelopmental conditions such as ADHD and autism, the links between different medical specialists will be even more important. Current research into the association between previous streptococcal infection and ADHD, Tourette's or obsessive-compulsive disorder<sup>19</sup> only serves to highlight the future role of medical research within child mental health. In the case of H, his parents were keen to find such a link, and he was screened for the autoantibodies associated with an increased risk for Tourette's disorder. In his case, however, these were not found, and his parents felt that they were therefore still looking and waiting for the correct diagnosis.

### Stigma in child mental health

The above debate around H's diagnosis raises the question of stigma, and the public's general understanding of medical conditions as opposed to behavioural problems. Is it better to be given a medical cause for a child's problems, proven, say, by a blood test, rather than simply focusing on the management of the child's behaviour, which would be the same regardless of aetiology? Part of the problem currently, is that public

among adolescents with type 1 diabetes: exploring relationships with temperament and character. *J Pediatr Psychol*. 2005 Mar;30(2):197-206.

<sup>19</sup> Rizzo R, Gulisano M, Pavone P, Fogliani F, Robertson MM. Increased antistreptococcal antibody titers and anti-basal ganglia antibodies in patients with Tourette syndrome: controlled cross-sectional study. *J Child Neurol*. 2006 Sep;21(9):747-53

perception of child mental illness is varied and often misguided, partly due to media hype and misinformation. A recent study in the USA found that many people do not regard ADHD as a mental health problem requiring treatment, as opposed to depression, and feel that general practitioners, mental health professionals such as psychologists and teachers will give more reliable advice than psychiatrists<sup>20</sup>. This is a very interesting result, as it implies that there is currently little faith in the knowledge or expertise offered by child psychiatry in general.

Medication also appears to be a big issue within the public understanding, with one study finding 86% of those questioned believed that doctors overmedicate children with behavioural problems<sup>21</sup>. Many parents felt that using medication increased the risk of stigma, both for the child and themselves. Clearly, as doctors are the only member of the CAMHS team able to prescribe, this may be part of the reason for the stigma associated with their role. It is, however, crucial for a good rapport to be established between doctor and patient in any clinical situation. Because child mental health is such a controversial issue in the media, it is essential for better information to be disseminated to the public at large, and the role of the child psychiatrist more clearly outlined and understood. Doctors themselves must be responsible for this information giving in order to present a non-biased perspective, with the support of the MDT. It is important not to underestimate the power of public opinion in influencing vulnerable parents of children with mental health problems.

<sup>20</sup> Pescosolido BA, Jensen PS, Martin JK, Perry BL, Olafsdottir S, Fettes D. Public Knowledge and Assessment of Child Mental Health Problems: Findings From the National Stigma Study-Children. *J Am Acad Child Adolesc Psychiatry*. 2008 Jan 22

<sup>21</sup> Pescosolido BA, Perry BL, Martin JK, McLeod JD, Jensen PS. Stigmatizing attitudes and beliefs about treatment and psychiatric medications for children with mental illness. *Psychiatr Serv*. 2007 May;58(5):613-8.

Many parents reject medication for the reasons outlined above, and it often requires the doctor to employ a collaborative approach with the parents, building up to starting medication over many sessions and with careful explanation at every step of the way. Whilst this is good clinical practice, many parents will not be persuaded, sometimes leading to sub-optimal care for the child in question.

Indeed, the effectiveness of medication is another key area of research for doctors in the future, as the current uncertainties as to the effectiveness of some medications for conditions in childhood, do not help to gain parental cooperation. For example, the controversy surrounding SSRIs in the treatment of childhood depression is ongoing. Even though fluoxetine has been shown to have some benefit<sup>22</sup>, more research is needed with larger trials and a consideration of the rare but serious side effect of suicidality. Clearly the balancing of side-effects and positive outcomes is an ongoing feature of psychiatric medication, and should certainly be an important and continuing area of development and research.

It is also worth noting at this point the disagreement even within the medical profession regarding certain medications and diagnoses. For instance, there are some doctors, including psychiatrists, who argue that conditions such as ADHD are over pathologised and should be seen as a cultural construct rather than as a condition that can be helped with medication<sup>23</sup>. These conflicting opinions may further confuse parents in a field of

<sup>22</sup> Usala T, Clavenna A, Zuddas A, Bonati M. Randomised controlled trials of selective serotonin reuptake inhibitors in treating depression in children and adolescents: a systematic review and meta-analysis. *Eur Neuropsychopharmacol*. 2008 Jan;18(1):62-73

<sup>23</sup> Timimi S. ADHD is best understood as a cultural construct. *British Journal of Psychiatry* (2004) 184: 8-9

medicine that is already controversial within the public domain.

### The doctor and the MDT

Of course, pharmacotherapy can never be the only treatment for a child with mental health problems. The important role of educational and clinical psychologists is paramount both in assessment and management of most children. Whilst doctors are also involved in the history taking and overall assessment of a child, including making the diagnosis and considering medication where appropriate, the overlap with the role of the clinical psychologist is not always clear to the general public. Clinical psychologists not only provide teams with detailed cognitive and psychological assessments, but can also offer behavioural and cognitive therapy where appropriate. This is an invaluable part of a child's management plan. However, as budget cuts are made and government policy is developed, the use of cognitive behavioural therapy (CBT) alone, even provided by a computer in some GP practices, may become a cheaper alternative to being assessed by a doctor or combined MDT. In the future, doctors may need to promote their role within child mental health, as an essential part of a full service.

Unlike colleagues in many other specialities, the child psychiatrist is just one part of a specialist team, and consequently an understanding of the different roles of allied professionals such as psychologists, social workers, speech and language therapists, family therapists among others, is crucial. In the future, more integration of services through the development of children's trusts is likely to be established. Each trust will house all those involved in the care of each individual child, including health,

education and social services<sup>24</sup>. These trusts highlight the need for doctors involved in child health and mental health to view their patient's needs holistically in order to adapt to future integrated approaches to child welfare.

Another important factor when considering child mental health is the future of the child in question. Whilst there may be good provision in terms of special schools and a supportive CAMHS team, what happens when the adolescent becomes an adult? The transition between childhood and adulthood is difficult for all young people, so it is likely to require even more input from appropriate services for those with mental health problems<sup>25</sup>. It is therefore essential for doctors within child services to liaise with those from adult services in order to arrange a gradual and hopefully smooth transition of care. This should minimise disruption for the child and consequently promote better mental health long term.

### Inpatient care

Currently, there is little national organisation of inpatient child and adolescent mental health services<sup>26</sup>. At present public opinion regarding such units is unexpectedly poor, and consequently national service provision is low. There is a concentration of units in London and the South East, and one third

<sup>24</sup> Bachmann MO, Reading R, Husbands C, O'Brien M, Thoburn J, Shemilt I, Watson J, Jones N, Haynes R, Mugford M; NECT team. What are children's trusts? Early findings from a national survey. *Child Care Health Dev.* 2006 Mar;32(2):137-46.

<sup>25</sup> Vostanis P. Patients as parents and young people approaching adulthood: how should we manage the interface between mental health services for young people and adults? *Curr Opin Psychiatry.* 2005 Jul;18(4):449-54

<sup>26</sup> O'Herlihy A, Worrall A, Lelliott P, Jaffa T, Hill P, Banerjee S. Distribution and characteristics of inpatient child and adolescent mental health services in England and Wales. *Br J Psychiatry.* 2003 Dec;183:547-51.

of units are privately funded. However, inpatient units can provide intensive focused care for children requiring such input, with a whole team of specialists around them. A recent study showed significant and sustained health gain in children following a period of inpatient admission across all diagnoses<sup>27</sup>. This may be partly due to lack of intensive outpatient programmes, but it does highlight the need for such services to be maintained and developed in order to offer children with complex mental health needs the best possible care. It is also important for these Tier 4 services to liaise with professionals working within the other tiers, in order to optimise the continuing care following discharge<sup>28</sup>, as well as listening to the service users themselves in order to ensure their needs are being recognised and met.

## **Conclusions**

What is the future role of the doctor in promoting child mental health? As we have seen, this is a complex question which requires an analysis of a number of different issues. From a detailed discussion of one individual case, we have seen how doctors are involved at every level, from the initial referral at Tier 1 to the eventual assessment by a specialist team. We have noted the importance of assessing every aspect of a child's life – on an individual, family and school level, seeing the child at the centre of a larger set of systems and understanding the influences and interactions within this. The need for early recognition and appropriate intervention is also discussed as a key role for doctors at

Tier 1 level in the promotion of good mental health. We have also looked beyond this, and assessed the issues faced by children such as H within society as a whole, including the potential stigma of a psychiatric diagnosis and its treatment. The important role of doctor as educator, both for other doctors and health professionals, but also for parents and the public in general has also been highlighted as crucial.

In the second part of this essay we have broadened our discussion, and considered the current contributions doctors are making within the fields of research, which should contribute to a better future understanding of the aetiology and management of child mental health problems. We have discussed the unique role of the doctor as one part of the MDT involved in child mental health, and the role of specialist services within this field, such as Tier 4 inpatient units.

What conclusions can we draw from these discussions? It is clear that the need for improved child mental health services is recognised, and that provision will continue to evolve. Traditionally the remit of doctors has been to apply a medical model of health when approaching any patient. Whilst this continues to be an important part of child mental health assessments, the need to extend this approach to encompass a holistic biopsychosocial model is also essential. Part of this requires collaboration with and integration of all the services involved in child welfare, including health, education and social services. Research and further developments in technology and our understanding of the brain will also shape the future of this field extensively, providing an incorporation of scientific understanding with social models of care, to allow doctors to fully understand and evaluate every aspect of a child's mental health problem. Perhaps, once we have been able to approach this level of

<sup>27</sup> Green J, Jacobs B, Beecham J, Dunn G, Kroll L, Tobias C, Briskman J. Inpatient treatment in child and adolescent psychiatry--a prospective study of health gain and costs. *J Child Psychol Psychiatry*. 2007 Dec;48(12):1259-67

<sup>28</sup> Street C. In-patient mental health services for young people--changing to meet new needs? *J R Soc Health*. 2004 May;124(3):115-8

knowledge and understanding, not only will public opinion recognise the invaluable role of the doctor within child mental health, but the children under the care of these services will achieve better mental health both as children and as adults functioning successfully within society.

**Dr Alicia Khan**  
Former Medical Student, now FY1,  
London.  
[aliciazk@gmail.com](mailto:aliciazk@gmail.com)

### Trainee News...

**Jo Barker**

Hello to all!

Omer Moghraby has now handed over to me the mantle of National SpR/St4-6 rep and I thought now would be a good time to introduce myself to you all. It was good to meet some of you at the residential in Liverpool and hear about some of the difficulties you are facing in your training, which I will be able to feed back to the Exec Committee at the next meeting.

There is now a Google group that we can communicate with each other on and to become a member of this please email me at [cap-reps@googlegroups.com](mailto:cap-reps@googlegroups.com). As the college cannot give out email addresses the impetus has to come from you to join! The good news is that we will be able to have a further Trainees conference in 2009 and this will hopefully be held in Winchester on March 27<sup>th</sup>. Although it's not the seaside venue some were hoping for it's a beautiful, historic city, which is really well situated with good transport links. Hopefully it will be as successful as last year's fantastic conference in London

and with this much advance warning hopefully you can all come!

In the meantime please do get in touch with me if you have any particular issues you would like me to bring up with the Executive Committee and please join the Google groups.

**Jo Barker**  
National SpR/St4-6Rep  
SpR on Wessex rotation  
[cap.sprs@gmail.com](mailto:cap.sprs@gmail.com)  
[joanne.barker@suht.swest.nhs.uk](mailto:joanne.barker@suht.swest.nhs.uk)

### Surveillance of Childhood Conversion Disorder in UK and Ireland to commence in October 2008.

**Dr Cornelius Ani**  
**Prof Elena Garralda**

Conversion Disorder is a serious condition characterised by motor and or sensory symptoms for which there are no or inadequate medical explanations. The symptoms are not intentionally produced and are associated with significant distress. Affected children are often severely impaired, require prolonged hospital admissions and are at risk of serious long-term complications including, additional psychiatric morbidity, educational failure, and social isolation. Conversion disorder is associated with extensive use of Child and Adolescent Mental Health Service and allied health resources.

Despite the huge personal suffering and health resources implications of Childhood Conversion Disorder, no systematic epidemiological study of the condition has been conducted in the UK and Ireland. We are therefore commencing a study to document the

burden, pattern, and short-term outcome of the disorder in these two countries. The findings will inform planning of services and allocating resources for caring for affected children.

The study will use a surveillance methodology conducted through the newly established Child and Adolescent Psychiatric Surveillance System (CAPSS). From October 2008, a card will be circulated monthly for 13 months to all Consultant Child and Adolescent Psychiatrists to report cases of Conversion Disorder seen. **Please report any new cases seen within that month. Details of the study are included in a protocol card which will be circulated in advance of the first notification card and is also available at <http://bpsu.inopsu.com>.** Paediatricians will be involved in a simultaneous surveillance of the disorder through the British Paediatric Surveillance Unit (BPSU).

The **case definition** is any child aged up to (but not including) 16 years with suspected or confirmed Conversion Disorder seen by a Child and Adolescent Psychiatrist for the first time in the last month. If the Child and Adolescent Psychiatrist is uncertain or awaiting confirmation, the child should still be reported.

A questionnaire will be sent to reporting clinicians to gather information on demographic factors, clinical features at presentation, evolution of symptoms, and clinical management of the case.

This study has MREC (Ref: 08/H0711/30) and PIAG (Ref: PIAG/BPSU 3-06(FT1)/2008) approvals, and is funded by BUPA Foundation. The surveillance is being run from the Academic Unit of Child and Adolescent Psychiatry, Imperial College London.

If you would like more information about the study or any advice regarding the eligibility of a particular case for reporting, please contact:

**Dr Cornelius Ani or Prof Elena Garralda**  
Academic Department of Child and Adolescent Psychiatry, Imperial College London  
[c.ani@imperial.ac.uk](mailto:c.ani@imperial.ac.uk)  
[e.garralda@imperial.ac.uk](mailto:e.garralda@imperial.ac.uk)  
Phone: 0207 886 1145

### Child in Mind: 'Training the Trainers' Workshops

**Luis Abraao**

*Now booking for November 08 in London and Liverpool*

The Royal College of Paediatrics and Child Health are pleased to announce dates for *Child in Mind* workshops this November. These are training workshops for trainers and co-trainers eg Senior CAMHS Nurses or Child Psychologists; who wish to use the *Child in Mind* materials to teach their SHOs. The materials can be downloaded from a password-protected online resource centre using the login details you receive after attending each workshop.

There are three stages: Stage 1 covers communication skills, somatisation and the paediatric assessment of deliberate self-harm; Stage 2 covers the paediatric assessment of behaviour in pre-school and primary school aged children; and Stage 3 deals with aspects of neonatal psychological development.

To find out more or download an application form visit

[www.rcpch.ac.uk/cim](http://www.rcpch.ac.uk/cim)

London	Stage 1&2	13 <sup>th</sup> Nov 08
	Stage 3	19 <sup>th</sup> Nov 08
Liverpool	Stage 1&2	6 <sup>th</sup> Nov 08
	Stage 3	7 <sup>th</sup> Nov 08

**Luis Abraao**  
**Project Administrator**  
[Luis.Abraao@rcpch.ac.uk](mailto:Luis.Abraao@rcpch.ac.uk)

## Invitation to join the Quality Improvement Network for Multi-Agency CAMHS (QINMAC)

**Ottile Dugmore**

Tier 2 and 3 CAMHS are invited to join the **Quality Improvement Network for Multi-agency CAMHS (QINMAC)**. This member-led network applies CAMHS standards in an annual process of self and peer-review, in order to improve the quality of Specialist Tier 2 and 3 CAMHS. Currently, over 60 CAMH teams are participating in QINMAC across England, Scotland and Wales.

Joining QINMAC enables CAMH services to learn from practice elsewhere in the U.K., demonstrate progress against key national policy, and to benchmark themselves against CAMHS nationally. Data from QINMAC reviews can also be used to inform the CAMHS Self Assessment Matrix. As one member comments:

*“(The QINMAC process) provided an excellent tool to evaluate our current performance across a range of standards. It gave a very practical and realistic view of strengths and areas for improvement, but also a comprehensive document to demonstrate progress against NSF Standard 9 and Standards for Better Health” - CAMH Service Manager*

Members can also opt to receive a **Learning Disability Review**. These reviews use the specially developed QINMAC Learning Disability Standards to evaluate CAMHS provision for young people with learning disabilities.

CAMHS in-patient units in your area are already participating in QINMAC's sister project, the Quality Network for In-patient CAMHS (**QNIC**). Many QNIC members attribute increased compliance with standards to their participation in the network.

For more information please visit <http://www.qinmac.org.uk> or contact Ottile Dugmore, QINMAC Programme Manager on 020 7977 6681 [odugmore@cru.rcpsych.ac.uk](mailto:odugmore@cru.rcpsych.ac.uk). If you would like your CAMH team(s) to join QINMAC please email [qinmac@cru.rcpsych.ac.uk](mailto:qinmac@cru.rcpsych.ac.uk) for an application pack. Application packs should be returned by **1<sup>st</sup> December 2008**.

**Ottile Dugmore**  
**QINMAC Programme Manager**  
[odugmore@cru.rcpsych.ac.uk](mailto:odugmore@cru.rcpsych.ac.uk)

## New Ways of Working in CAMHS

**Tim Morris**

The NWW in CAMHS project reports have now been published. These highlight the potential positive benefits of making appropriate changes and some of the difficulties in embedding change within the current NHS culture. Whilst covering a range of staff groups two reports have a substantial focus on the work of child psychiatrists with reports from Derbyshire and North Staffordshire. All the reports

are available on the web at: [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk).

Hard copies or CD versions can be obtained from Barry Nixon at [barry.nixon@wvl.nhs.uk](mailto:barry.nixon@wvl.nhs.uk) or Tim Morris at [Timmerri@liverpool.ac.uk](mailto:Timmerri@liverpool.ac.uk)

**Tim Morris**

[Timmerri@liverpool.ac.uk](mailto:Timmerri@liverpool.ac.uk)

(Please note there is no 's' in morris...this isn't a typing error! The Editor)

## **National CAMHS Review (Dept for Children, Schools and Families: DoH, England)**

**Raphael Kelvin  
Margaret Bamforth**

Bob Jezzard and Jo Richardson are leading this review and are now finalizing the conclusions to put before the ministers, Ed Balls/Alan Johnson.

The Faculty Executive has submitted a summary response and evidence. The Faculty response draws on a number of different evidence bases which includes data provided by the recent college survey that so many of you responded to, thanks for that. If you want to know more read on...

You can find the following further information on the faculty webpage:

- PDF summaries of your responses to the survey (Consultants, asked to respond one per service)
- Word summary compilations of the responses from colleagues in England
- A PDF file showing cross national comparisons of number of consultants in Child and Adolescent Psychiatry per child head of population across Europe

- A word file containing the Faculty National CAMHS Consultation response

See

[www.rcpsych.ac.uk/college/faculties/childandadolescent.aspx](http://www.rcpsych.ac.uk/college/faculties/childandadolescent.aspx)

### **Summaries**

#### **1. The Faculty survey findings**

The survey returns represented around 60-70% of tier 3 services; a reasonable hit rate, and 27 responses from tier 4 in England, probably also around 70% of services (estimates).

Around 75 % of services reported no increase or indeed decreases in resources in the last 2 years.

The same proportion report more work and lower moral in the same time period. 80% report the NSF has led to increased workload and pressure.

A theme emerges of services being asked to take on additional workload eg LD or 16-18 year olds without commensurate additional funding.

The view is the NSF has so far, been used to increase pressure on already hard pressed services rather than support and grow services for many of this 75% of services reporting. This is rather contrary to some of the stated aims of the NSF, which highlighted the importance of enabling core specialist services to grow and develop, and recognized the need for managed work loads and large unmet demand.

#### **2. The Faculty response to the National CAMHS Review consultation**

The response of the Faculty highlighted the very low baseline of current services even after the welcome investment that has flowed in recent years; no more than 30% of those kids (around 1-1.5% of the child population) who should be seen in CAMHS tier 2/3 are seen.

Staffing levels are similarly not adequate to meet the needs of the 3-4% who should be seen in tier 3 or the 6-7% who should be seen in tiers 1-2.

We further highlighted some specific issues; such as weak commissioning, fault lines in processes eg affecting services like tier 4 children's units, hospital liaison services; the lack of account taken for the consequences of closing so many local authority supports for kids without providing the community infrastructures including CAMHS to pick up the workload arising, and so forth.

We drew attention to our very low levels of staffing by any West European Comparison, 11<sup>th</sup> out of 11 similar countries and the parallel poor outcomes for our kids, 22<sup>nd</sup> in the recent UNICEF child wellbeing league table.

We then proposed some solutions!..... both at the level of CAMHS service delivery and also at the level of some of the determinants of ill health/ ill mental health of young people in the country.

We proposed a change in how Government's legislative and policy processes are enacted; that all legislation and policy, could have to be put through a test, will it be beneficial, harmful or neutral to the health and wellbeing of children and families? If so what might the costs be? An expert evidence based, 'National Children's Advocacy Body' could be a reference body for such a test of all policy and legislation.....we might then build cycle paths beside each road, review advertising legislation and food stuffs and then build environments for children and so forth.....well you never know, they do this in Finland so maybe we can too!

If you want to know more see the weblinks above.

**Raphael Kelvin and Margaret Bamforth**  
(on behalf of the Faculty Executive Oct 08)

[raphael.kelvin@cpft.nhs.uk](mailto:raphael.kelvin@cpft.nhs.uk)

[margaret.bamforth@merseydeanery.nhs.uk](mailto:margaret.bamforth@merseydeanery.nhs.uk)

## Workforce Planning Committee; National Workforce Development

### Raphael Kelvin

I became the Faculty representative to this quite new College committee (chair Sally Pidd) in the spring this year.

I have been getting to grips with the rather complex process of national workforce planning. I have put together a discussion paper on the subject which is being considered within the faculty exec and the workforce committee.

Note: When I am highlighting the need for more Consultants, it is always in the frame of part of an MDT; and so if we need 1 more consultant we generally need at least 6-7 more non medical MDT colleagues to form the team within which we can together be most effective.

The workforce discussion paper includes an analysis of where we are currently with our workforce; how that compares with where we want to get to as described in the NSF and college workforce recommendations; how we compare to other comparable West and North European economies; and what we might need to do to get there.

The tables below are summaries for your interest and consideration.

The major issues the data highlights are

- that current growth rates of consultants as projected over the next 15 years by the DoH workforce analysts are insufficient; currently around 10-20 additional posts per year are added to the workforce of around 560 full time equivalents in England. For additional info, there are around 100 SAS grade docs in child psychiatry in England at present.
- To get to where I think we should be as determined by application of the workforce data and subsequent analysis we should be adding around 50-60 new additional consultants per annum, an increase of around 40 pa.
- To achieve that we should be rolling about 3-4 additional CCTs off each and every training scheme across the country per annum
- Each year for the next 15 years
- We then reach around 1400 full time equivalents by 2023 which would match the NSF and college recommendations, assuming the population count remains at 50 million for England (which is unlikely) and that levels of psychopathology/ needs don't grow more (as they have done in the last 30 years see Collishaw and Maugham cohort studies)
- Yet we would still then only be around the midpoint, using current workforce data, of a league of 11 comparable European economies (France, Germany, Netherlands, Belgium, Switzerland, Norway, Denmark, Finland, Sweden, Italy)
- And by then, 2023, these countries will have advanced their workforce; for example the Norwegians who base their services very much on our MDT models are commissioning specialist services to see 3-4% of the Child population per annum v our current level of 1-1.5% (personal communication).

- So the question now being addressed is how we tackle these issues

*Summary results arising from this discussion paper*

- 1. How does this translate to College/NSF Recommended workforce? See Table 1 on the additional sheet at the end of the newsletter.**
- 2. And what is the recent past and projected expansion of FTE consultant posts and its implications for training numbers? See Table 2, at the end of the newsletter.**

#### **Note**

By comparison **Paediatrics** currently have **2000 FTE** and plan to nearly double to circa **4000 FTE by 2023**

Current ratio is 1 Child psychiatrist per 4 Paediatricians, if current growth plans are followed to 2023 (840 FTE) the ratio will fall to 1 per 5 Paediatricians.

The next steps:

- I am taking it to inform the wider college of these issues; they come as some surprise to colleagues in the other faculties judging by feedback from the recent workforce committee where I presented this paper.
- I am redrafting the college's input to the DoH/Workforce Review Teams summaries which are sent each year to all SHAs/Commissioners and Trusts to inform local workforce planning priorities

- The Faculty exec plans to consider its strategic response further at the next strategy day in the spring
- I am linking with CSIP national workforce lead Barry Nixon and our DoH rep Anne York to consider these issues further
- I will be looking to refine this data and the associated arguments in coming months; any cross national comparisons of outcomes for children data would be welcome, I know that colleagues at the IOP- Robert Goodman has published in this regard.
- I am in the process of contributing to an updated description of the roles, responsibilities and benefits of having a consultant in child and adolescent psychiatry in the MDT to the document that the college jointly produces with the DoH; 'Joint Guidance on the Employment of Consultant Psychiatrists'  
Produced by Royal College of Psychiatrists + NHS Confederation + National Mental Health Partnership.  
This is a guidance intended for Trusts, regional advisers, and commissioners of mental health services to understand the factors involved in:
  - creating roles for consultant psychiatrists
  - maintaining current posts for consultant psychiatrists
  - recruiting psychiatrists for those roles
  - developing effective working relationships for consultant psychiatrists
  - promoting new ways of working

We will keep you posted on developments.

**Raphael Kelvin**

**Faculty representative to the College Workforce Committee) Oct 08**  
[raphael.kelvin@cpft.nhs.uk](mailto:raphael.kelvin@cpft.nhs.uk)

### Dates for the diary...

January Institute Meeting: Friday 16th January. The Mental Health and Mental Capacity Acts: A Developmental Perspective

The Faculty Residential 2009: September 9-11, Dublin. Details to follow...

### Spotted at the Residential conference in Liverpool...

#### The Editor

...Ken Dodd in the main hall at the Adelphi with his famous tickle stick...he was captured on camera with Andrew Charters (Barnsley)....

**Kay Harvey**  
Editor

### Your contributions to this Newsletter are welcome!

Please send any contributions for the next newsletter, which will be published in January 2009, to the email address below by Mid December.

[kayharvey163@hotmail.com](mailto:kayharvey163@hotmail.com)

### Contacts

**Dr Greg Richardson**

Royal College of Psychiatrists  
[Greg.Richardson@sypct.nhs.uk](mailto:Greg.Richardson@sypct.nhs.uk)

**Dr Kay Harvey**  
[kayharvey163@hotmail.com](mailto:kayharvey163@hotmail.com)

**Greg Smith**  
Royal College of Psychiatrists  
[gsmith@rcpsych.ac.uk](mailto:gsmith@rcpsych.ac.uk)

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**The End**

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