



# The Newsletter



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## Editors column

Welcome to the Spring Edition of the Faculty Newsletter!

With the growing concern about our environment I feel rather guilty that this newsletter is still printed on paper and then posted out to all our members in this country and around the world. Prior to the next newsletter in June I will look into the possibility of making an electronic version instead. Please let me know if you have strong feelings about this, either way!

For your information previous editions of the newsletter are now available to view on the college website, in the Child and Adolescent Faculty section.

**Kay Harvey**

## In this issue...

We have updates from the Executive in The Chair's report from Greg Richardson....information from the Iraqi Association for Child Mental Health...

We have a report from the trainee representative - Jo Barker ....and information about future events.

We also have information about 'Child in Mind' Train the Trainers from the RCPCH.

## The Chair's Column

### Greg Richardson

13 members of the Executive and the regional representatives met for our Faculty Strategy day on 11<sup>th</sup> March. We set about addressing what sort of workforce CAMHS will need to provide an effective service to children and young people in the future. For England we were able to focus on what would be needed to fulfil the CAMHS Review but hoped our suggestions may be helpful to all child and adolescent psychiatrists. We could not have had such an informed discussion if Raph Kelvin had not had so many important figures and so much important information, so we just couldn't have done it without him.

The results of our ruminations were:

#### **What child and adolescent psychiatrists need to know:**

- To be prepared for the changing contexts in which we operate
- How to work with local managers and commissioners, some of whom have no knowledge, and some a willful ignorance of modern CAMHS practice.
- How the shape of the workforce will affect service delivery (see Raph's paper on staffing needs for e.g. a LAC team or to provide services for 16 and 17 year olds), so being clear about what will be available for set resources.
- Will the future consultant psychiatrist be a multi-skilled service leader who deals with the anxiety producing problems that cause other CAMHS members to look to them, or will they be a highly trained therapist spending more time in face to face contact

(which may be like continental counterparts who are more numerous and not as well paid).

- What would a model workforce and service specification look like, say for a population of 250,000?
- What commissioners are prepared to pay for and being clear with them what they can expect for their money.
- How to use the National Council in England for the benefit of services
- How to prepare for revalidation and job planning.
- What the curriculum looks like
- What tasks should child and adolescent psychiatrists restrict themselves to.
- The Standards they should be advising commissioners and managers need to know about for safe and effective CAMHS
- Awareness of quality audits in CAMHS starting with QINMAC and QNIC, but also auditing capacity to meet NICE guidelines.
- How to provide services for increasing numbers as we address unmet need in the community and the increasing incidence of morbidity (assuming 10% mortality we currently see 1.5% and need to meet needs of at least 3.5%).
- How to involve users, carers and the public in service development and lobbying of local commissioners.

#### **Suggested solutions**

- Update the Building and Sustaining Specialist CAMHS document in light of Raph's papers to indicate the staffing required to meet the needs of the increasing numbers of young people recognised as being in need of CAMHS. Figures for Scotland are available in their workforce document of 2004.
- We probably need two documents, one for the psychiatric workforce as

a College document about the role of psychiatrists and another to submit to the National Advisory Council as a basis for describing a multi-disciplinary workforce for CAMHS delivery as they have to "Produce a single document to clarify individual and joint responsibilities for children's mental health and wellbeing and ensure a joint approach". If we can produce a short document for all CAMHS setting out the requirements to meet the mental health problems of the communities they serve, this could be promulgated locally by child psychiatrists to MPs and councilors.

- The arguments used must be based on the needs of young people and families not on what suits professionals.
- We must separate the need for services for the mentally disordered from the societal support required to raise emotionally healthy children. CAMHS provide the former and may be able to offer advice on the latter, but it is not CAMHS responsibility.
- Develop a quality directory for CAMHS using QNIC and QINMAC and ability to meet NICE guidelines.

### **The questions we need to address**

#### **1. How quickly do we want to grow?**

Recommended growth is 10% p.a. for the next fifteen years.

Suggest 5% for 2010, 6% for 2011, 7% for 2012, 8% for 2013, 9% for 2014, 10% for 2015 and review in 2015.

#### **2. How quickly can we grow?**

This will depend on

- increasing specialisation of child and adolescent psychiatrists,
- The public visibility of unmet needs,
- Our marketing skills
- What happens when run through training ends?
- Availability and usage of foreign graduates.

What can we learn from the success of Paediatrics in growing?

#### **3. Do we need to grow tier 4 staffing?**

Yes in all tier 4 areas:

- newly developing adolescent forensic services
- newly developing CAMHS for deaf children
- In-patient services, as more are required, but 15% might be cared for in the community by Assertive outreach and Crisis Teams that have 3-5 patients for each staff member. (ACT Assertive community Treatment teams)

All tier 4 services require consultant psychiatrist input.

A staffing baseline for the proportion of FTE of all disciplines necessary to staff one inpatient bed (in a 10 –12 bedded unit, as fewer beds than this becomes disproportionately expensive).

#### **4. Are in-patient requirements of 20-40 beds per million total population still relevant?**

These figures are up to date for Scotland.

CAMHS mapping would show how far England and Wales are falling short of

this target, except that CAMHS mapping does not include the independent sector, which provides one third of in-patient beds.

In-patient bed need requires better definition

### **5. Is the requirement for 1FTE consultant psychiatrist for 10-12 in-patient beds still relevant?**

Yes, as a minimum, but if there is more than 1 consultant then there should be at least 1.2 FTE per 10-12 bed unit and more if there are more beds.

### **6. Can we increase the percentage of medical students choosing psychiatry as a career?**

By offering:

- Special Study Modules and Electives.
- Wider advertising of the student essay prize.
- Taking up roles in medical schools and academic departments
- Link with paediatric student placements
- Stalls at student fayres
- Student trainee links
- More F2 posts.

There is a Scottish Division Undergraduate Training Group

### **7. Can we increase the percentage of psychiatric trainees choosing child and adolescent psychiatry?**

The withdrawal of the College requirement for a six month placement in developmental psychiatry (child and adolescent psychiatry or learning disability) may affect recruitment adversely.

Not if there are unfilled consultant posts, even if the reason they are unfilled is because they are undesirable. (There is a 20% vacancy in Scotland). Posts that are altered to become desirable soon get filled.

Is our higher training good enough?

### **8. How can we increase the number of consultant posts, and make new posts desirable?**

The difficulty may be holding on to the posts already in existence, rather than increasing posts.

How do we keep people in posts?

How do we make jobs "bearable"?

Utilise the public especially the evidence from adolescents that they want good assessment that leads to early accurate understanding and appropriate help, not multiple meetings with people who fail to grasp what is really the problem/s to lobby PCTS, MPs etc. This is cost effective as poor services are very wasteful and upsetting for the users and carers.

Encourage CAMHS professionals to sit at the right "tables" (e.g. PCT boards, Trust boards).

Is there a value for money evidence base that could be brought to bear on this e.g. how cost effective are consultants how much money do we save not just how much do we cost?

### **9. How do we ensure proportionate multidisciplinary development in community CAMHS and in-patient CAMHS?**

Bear in mind the EWTD.

The ratio of consultant psychiatrist time to the time of other disciplines will vary from

1:3 to 1:10 depending on the critical mass of the service. Smaller services require proportionately more consultant psychiatric time.

Are trainees supernumerary, they can't really be considered as a substantive part of service delivery.

### **10. How is funding secured for increased NTN's?**

Be open to public, commissioners and government about a better evidence base for the need for the structure of CAMHS and the resources needed to support that structure.

Breaking circular arguments that jobs aren't filled so what is the point in training.

In Scotland training posts won't be developed unless there are jobs for them.

Lobby Children's Commissioner.  
Good local succession planning.

Dependent upon training capacity of current consultants in child and adolescent psychiatrists.

So we are intending to update "Building and Sustaining Specialist CAMHS" with up to date figures and evidence and to use it to point towards relevant documentation. Any-one want to help??

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

### **Trainee News...**

**Jo Barker**

Dear all,

I am writing this just after the Annual Higher Trainees Conference in Winchester. The day was very successful and we received great feedback with many commenting how important it is to have a special day once a year just for Trainees. It sounded like all enjoyed the mixture of lectures and workshop about the subspecialties within our specialty. A full report of the conference will follow in the next newsletter. Exciting news is that Dr Sunanda Ghosh from the Eastern Deanery was elected as the next National SpR/ST4-6 Rep, so we can all look forward to next years conference that will be held for the first time in Cambridge!

As for other news at the recent CAPFECC meeting we discussed trainees being involved in producing appropriate stations for the CASC and if this is something you are interested in please contact Dr Palekar, head of examinations ([fpalekar@rcpsych.ac.uk](mailto:fpalekar@rcpsych.ac.uk)).

A survey will soon be going out to all psychiatric trainees to get their views about how important they see a post in developmental psychiatry in their training. I urge you all to fill this in so we can collect some positive evidence that our specialty is important for all trainees. Please contact me anytime if you have any issues that you would like me to bring to the Faculty or CAPFECC.

**Jo Barker**  
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**Arabic version of the Royal College factsheets for parents, teachers and young people.**

## **Dr Abdul Kareem AIObaidi**

The Iraqi Association for Child Mental Health (IACMH) is a non - governmental organization established in May 2004 by a group of medical specialists in psychiatry, paediatrics, community medicine, and professionals in psychology, social work, learning disabilities, as well as child advocates. The association has been registered to operate in Iraq, and is a member in the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP). Its main role is to develop child mental health, to promote programs to protect children from neglect and abuse —by raising the awareness of people working in health services and in the community at large— and to develop professional skills in this field . The organization holds conferences, lectures, forums, and workshops. In addition it distributes letters, leaflets and books concerning child mental health issues. The long-term strategy is to provide services for children in need.

As a major contribution to raising awareness of child and adolescent mental health problems, five members of IACMH have produced Arabic versions of the Fact Sheets for parents, teachers and young people , one of the publications of the Royal College of Psychiatrists, Mental Health and Growing up series (Third edition, Edited by Gillian Rose and Ann York).

You can access the Arabic version through the link:

<http://www.rcpsych.ac.uk/mentalhealthinfo/translations/arabic/mentalhealthandgrowingup.aspx>

We would happy to cooperate with any further publications.

**Dr Abdul Kareem AIObaidi**

**Chairman of Iraqi Association for Child Mental Health (IACMH).**

[kareemobaidi@gmail.com](mailto:kareemobaidi@gmail.com)

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

### **Training in Child Mental Health and Neonatal Wellbeing for Paediatricians**

'Child in Mind' is an initiative of the RCPCH, with support from the RCPsych and the BPS, to design training materials for paediatricians in child mental health as it relates to Paediatrics (paediatric mental health).

If you are a senior paediatrician or CAMHS professional, you can get involved by booking a place at one of the upcoming 'Training the Trainers' workshops. Each workshop will take prospective trainers (paediatricians) and co-trainers (child mental health professionals) through everything surrounding the delivery of 'Child in Mind' seminars to junior doctors (ST 1-3).

### **Child in Mind Train the Trainers: Stages 1 & 2 combined**

**7<sup>th</sup> May 2009 or 13<sup>th</sup> November 2009**

### **Child in Mind Train the Trainers: Stage 3**

**20<sup>th</sup> May 2009 or 26<sup>th</sup> November 2009**

Stage 1 and stage 2 deal with: somatisation and the paediatric assessment of deliberate self-harm; communication skills; and the paediatric assessment of behaviour in pre-school and primary school aged children. Stage

3 covers several aspects of neonatal psychological development.

For more info or to download the application form(s) visit [www.rcpch.ac.uk/cim](http://www.rcpch.ac.uk/cim) or contact the project team on [childinmind@rcpch.ac.uk](mailto:childinmind@rcpch.ac.uk). Or 020 7092 6110.

**Luis Abraao**  
Education Projects Administrator

### Post traumatic Stress in Preschool Children: Assessment and Evidence Based Treatment.

#### Post traumatic Stress in Preschool Children: Assessment and Evidence- Based Treatment

**Date:** 21-22 November 2009

**Venue:** UCL Institute of Child Health,  
London

A practical workshop intended to give participants a working knowledge of the nuts and bolts for everyday clinical work. The course will demonstrate how to use CBT techniques and how to identify feelings with preschool children, use a stress thermometer, build a stimulus hierarchy and use relaxation techniques. Speaker: Michael S. Scheeringa, Associate Professor, Dept of Psychiatry & Neurology and Clinical Assistant Professor, Dept of Paediatrics, Tulane University, New Orleans, USA

**Contact:** For further details and to register see

[http://www.ich.ucl.ac.uk/education/short\\_courses/courses/2S-78](http://www.ich.ucl.ac.uk/education/short_courses/courses/2S-78)

Email: [info@ichevents.com](mailto:info@ichevents.com) Tel: +44 (0)7813 8394

### Paediatric Liaison Interest Group

#### Derek Proudlove

*This article is being reprinted as Derek's email address was wrong in the last newsletter – please try again if you failed to contact him last time!*

The paediatric liaison email forum for child and adolescent psychiatrists was founded in 2002. We now have over 120 members including many international members. The forum is used to discuss clinical questions, current practice, research, service development and national policies.

We also meet twice a year for a full day, often with invited speakers, and a chosen theme.

Meetings usually alternate between London and other venues such as Edinburgh or Liverpool. Many of the best known experts in the field are members of the group such as Elena Garralda, Mary Eminson and Sebastian Kraemer. We welcome any child and adolescent psychiatrists, including trainees, who may be interested.

If you would like to join please email [derek.proudlove@alderhey.nhs.uk](mailto:derek.proudlove@alderhey.nhs.uk)

**Derek Proudlove**  
[derek.proudlove@alderhey.nhs.uk](mailto:derek.proudlove@alderhey.nhs.uk)

### Royal College of Psychiatrists Events

## Elizabeth Edgar

### Depression in Children and Young People

Thursday 2<sup>nd</sup> July 2009 – London, £295\*

\*Delegates who attended the trilogy will receive a 50% discount off this fee.

This conference will provide you with a worldwide perspective on the review of evidence, an opportunity to consider the relative benefits of medication and psychological treatment and to hear about a patients' experience.

### Neither hopeless nor helpless.... Innovative approaches to complex and hard to reach young people and families.

Thursday 8<sup>th</sup> October – London, £195

Thursday 5<sup>th</sup> November – Leeds, £195

Topics include:

Designing and delivering services for complex, hard to reach, helpless and hopeless populations.

Dialectical behaviour therapy, home based treatment services and multimodal approaches.

For more information and a booking form visit [www.rcpsych.ac.uk/cetc](http://www.rcpsych.ac.uk/cetc)

Enquiries to: Elizabeth Edgar, Regional Development Manager, Education & Training Centre

[eedgar@cru.rcpsych.ac.uk](mailto:eedgar@cru.rcpsych.ac.uk)

Tel: 0113 366 3248

## Dates for the diary...

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

## Your contributions to this Newsletter are welcome!

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

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

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## The End

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