



# The Newsletter



## C & A Faculty Executive Committee

### Elected Officers

Sue Bailey Chair, Manchester  
Ann York Hon. Sec., Surrey

### Elected

Marjorie Baillie	Hexham
Margaret Bamforth	Cheshire
Pauline Forster	Birmingham
Tony Kaplan	Edgware
Clare Lamb	Colwyn Bay
Paul McArdle	Newcastle upon Tyne
Margaret Murphy	Cambridge
Paul Ramchandani	Oxford
Siôn Roberts	Cheltenham
Margaret Thompson	Southampton
Michael van Beinum	Hamilton
Kate Wurr	Leeds

### Co-opted

Tom Berney	LD link
Sally Bonnar	CAPSAC
Gillian Davies	Welsh Division
Sandra Davies	Scottish Division; Obs. for Scottish Executive
Brendan Doody	Irish College of Psychiatrists
Louise Ementon-Shaw	CTC alternate
Sue Goodwin	SpR
David Jones	Academic secretary
Steve Kingsbury	Past hon. secretary
Anne Murray	Northern Irish Division
Stephen Stanley	Chair, Regional Reps
John Talbot	Hon. sec., Regional Reps
Paul Tiffin	CTC alternate
Morris Zwi	Sponsorship lead

### Observers

Amanda Burke	Irish Dept
Bob Jezzard	DoH
Daphne Keen	RCPCH
Catherine McLaughlin	FOCUS
Ian McMaster	N. Ireland Dept
Richard William	Welsh Assembly

Gill Gibbins

Assistant Secretary

## Please fill in and return the questionnaire

## *In this issue...*

- Sue Bailey talks about Faculty and College news and asks you to take part in a questionnaire (enclosed)
- Ann York talks about the executive strategy meeting and the last executive meeting
- Jim Rose talks about the Nurture Group Network
- Anne Murray, Faculty Chair of the Northern Ireland Division, gives us a snapshot of the key issues in Northern Ireland
- Conferences

## The Chair's Column

This started as a short column but there is a great deal happening. **Please complete the questionnaire in this newsletter - what you say will drive forward the strategy and priorities of the Faculty.**

Whatever the many uncertainties and challenges, within and without the College, overall Cinderella CAMHS has had a voice over the last three years, although sadly sometimes with too few solutions. However, it looks as though CAMHS will continue to have a voice as the governments across the jurisdictions are engaging with us, at all levels of needs mapping, planning and policy.

- We are about to start the College CAMHS funding study, working with the College Research Unit
- We are about to have the findings from the Expert Witness Survey, and updated information you can provide (see questionnaire) will be invaluable
- The Children's NSF England (allowing for any unforeseen circumstances) is due out in early autumn.
- In England the recently announced Treasury Spending Review, Child Poverty Chapter 5 has announced that the PSA target for CAMHS will continue beyond 2006. This means ongoing monies with associated hard work.
- In England the 'Mental Health Tsar', Professor Louis Appleby, now has lifespan responsibility for mental health including CAMHS.

Transitions are always tricky. The College Mental Health and Emotional Wellbeing Group have started to achieve funding for a Forgotten Years project for 9- to 13-year-olds. If you know of any "Angel" funders for some more funding, please let me know.

We will all be busy and pre-occupied with how to achieve on the multiple interface CAMHS work up to 18, with continuing workforce challenges even with New Ways of Working. A really important transition is 16- to 21-year-olds. We do have early onset psychosis teams, not enough, and not enough monies. We don't have transitional services for those 16- to 21-year-olds heading towards adult ASPD and Borderline PD, but we know that this group place a tremendous burden across all adult services while suffering distress which spills out into their families and society.

- At present the future path of training across medicine is uncertain, but the clear

implications are that all governments will want to generate more consultants in all specialties more quickly. We can therefore expect future debate within and outside the College about how many CCSTs, and can therefore expect to have to continue to argue strongly for the continuation of a CCST (or new equivalent) in Child and Adolescent Psychiatry.

- We are being listened to about "orphan" prescribing – SSRIs and I will report back further in September.
- In keeping with New Ways of Working, the training curriculum for paediatricians wishing to develop special skills in CAMHS is progressing well and we start work with the Royal College of General Practitioners shortly, so some GPs can gain enhanced CAMHS skills in a Tier 1 context.
- The President is very aware of the acute workforce issues in Northern Ireland, and in his last year as President is focusing on Children in Special Circumstances, especially "looked after" children and young offenders.

I am not naïve about the enormity of the task we face in CAMHS and the burden on child psychiatrists, but we now have a real voice - we have to take and grasp each and every opportunity presented to us to deliver effective services to young people and families in our working life as professionals; but as practitioners who also have family, friends and a life outside work.

For those of you having a break, enjoy, but please find time to answer my questions and I will collate your answers and present them back to you in Edinburgh.

**Sue Bailey**  
Chair, Faculty of Child & Adolescent Psychiatry

20 July 2004

## Café News

**Child and Adolescent Faculty  
Executive News**

There has not been an Executive meeting to report on since the last Newsletter but I thought that I would take the opportunity to update you on some other issues. The next Executive is in September, at the Residential conference.

### *Tiers 1 to 4 Demand and Capacity paper*

We are still on target to launch this at the residential conference. It is clear from the correspondence and conversations that I have been having with many of you that this is eagerly awaited. Everyone seems to want clarity as to what is 'core' CAMHS, what size teams should be and (the other side of the same coin) what is the capacity of the existing service.

There are also anxieties. Most services are chronically struggling to manage their demand and are worried that the gap between their current position and the 'comprehensive' CAMHS is so large that commissioners will push any guidance to one side. We are hoping to produce a document that is sensitive to all these concerns and a useful way to open effective dialogue between you and your commissioners about what your service needs.

### **Mental Health and Growing Up Fact sheets**

The updated new version of this series is now available from the College. They were launched at the AGM in Harrogate in July and will be available at our Faculty residential conference. You can also download them from the website.

See you in September.

**Ann York, July 2004**

### **Jim Rose talks about the nurture group network**

#### **Nurture Groups – effective early intervention for vulnerable children**

Nurture groups have existed for over thirty years. They were the response of an educational psychologist, Marjorie Boxall, to the distress of many pupils and staff in schools in the Inner London Borough of Hackney in the late 1960s, as shown in the unmanageable number of requests for children to be placed in special schools for the 'maladjusted' and the 'educationally subnormal' or for psychiatric treatment.

#### **What are nurture groups?**

In the so-called 'classic' model, nurture groups are classes of 12 or so children with their own teacher and learning support assistant, set up in primary schools with their own room, preferably in a central part of the school. The group is an integral part of the school's provision, understood and supported by all the staff. The training for nurture group staff emphasises the importance of valuing the child as s/he is and responding to them at whatever developmental stage they might have reached; whether they need comfort and physical contact like a baby, control like a two-year old in a tantrum or repeated explanations like a three-year old at the 'Why?' stage.

The children register with their 'base' class, are collected by group staff, spend most of the day in the group room, returning to their base class for the last half hour of the day. Nine of the ten sessions in each week are spent in the group, the children keeping contact with the rest of the school by joining them for midday lunch and at playtime. Staff have one afternoon session for recording and planning, for training or for formal meetings with parents. On average children will spend up to four terms in the nurture group before re-joining their mainstream class.

In many schools there are variations on the above, usually in terms of the length of time spent in the group each day or more involvement with their mainstream class in certain subject areas, but nurture groups always work to the essential principles encapsulated in the above description, i.e.

- Children's learning is understood developmentally
- The classroom offers a safe base
- Nurture is essential for the development of self-esteem
- Language is a vital means of communication – more than a 'tool' it is a vehicle for expressing emotion and feeling
- All behaviour is communication
- Transitions are important in children's lives

#### **A whole school approach**

Nurture groups cannot exist in isolation in a school. They must be owned by the whole school community and research shows the overall benefit that a nurture group can bring: *'Schools that have nurture groups achieve significantly higher gains for pupils with SEBD, both in the nurture group and in the mainstream class, than schools which do not have nurture groups. The qualitative data in particular indicate that mainstream staff develop more 'nurturing' approaches to pupils on the basis of their interactions with nurture group staff. These interactions are supported by the tangible benefits accrued by nurture group pupils from their placement in the group, which are reflected in their*

*mainstream performance as observed by mainstream staff. (Cooper, Paul (2002) The Nurture Group Research Project, Leicester University)*

It will be clear from the above that nurture groups are a school-based intervention, developed for use with what would now be designated Key Stage 1 children. In practice nurture groups are running at Key Stage 2 and in many pre-school settings the ideas and principles of nurturing are informing practice for the whole provision. Interest is also being shown at secondary levels, with nurture group principles being used to provide support for children experiencing difficulty in what is a major transition, from primary to secondary school. There is even a nurture group in a Young Offenders Institution, recognised and praised by both OfSTED and the Prison Service Inspectorate! Nurture groups make a powerful impact on individual children, parents and teachers as well as on whole schools. The Leicester research project, reinforced by individual project evaluations, demonstrates consistent progress in children's behaviour and attainments and the sustaining of these improvements following their return to full-time mainstream classes. Over 80% of nurture group children were found to be successfully placed in the mainstream two years after leaving the group.

Effective early intervention is increasingly recognised as having longer-term benefits to children. Nurture groups help children to re-establish good relationships with adults and begin to see school as a place to experience success. The positive experience of the nurture group increases those factors in children that support and increase resilience. Regular school attendance and positive friendships are important protective factors against involvement in delinquent behaviour through negative peer group influence or the onset of mental health problems for those children whose earlier experiences of being looked after may have been less than adequate.

The study of child development and its relation to mental illness has existed for many years. The importance of attachment was recognised by the inclusion in the American Psychiatric Association's DSM IV (1994) of *Reactive Attachment Disorder* and the concept is now well accepted throughout the psychiatric world. In the past two decades there have been exciting advances in understanding the genetic basis for certain mental illnesses, but however clearly this can be ascertained there is always the reservation that 'untoward life events' can provoke a breakdown which would not otherwise occur. Now it is widely accepted that early deprivation leaves its mark; the damage is real, encoded in the nervous system, so that the sooner remediation takes place the better the chances of recovery. This acceptance stems from rapid developments in neuropsychological

research, showing how babies need warm human attention if their nervous system is to develop well and that sustained emotional neglect or ill treatment will cause measurable damage to a child's brain.

Nurture groups have a long and impressive history. They are recognised by the DfES as a credible model for early years intervention and acknowledged in a number of important policy documents, e.g. *Excellence for all children: Meeting Special Educational Needs*, the Programme for Action, in *Social Inclusion: Pupil Support* and in *Promoting Children's Mental Health*.

### **The Nurture Group Network**

The Nurture Group Network is the central organisation for the promotion of nurture group work across the United Kingdom and the assurance of its quality. A largely autonomous division of the old-established charity, SEBDA, (Social, Emotional and Behavioural Difficulties Association) it has grown from a small group of people experienced in nurture group work and now has a formal constitution, membership, an executive committee and a National Council with representatives from all over the United Kingdom. It publishes a Newsletter, and has a soon to be upgraded website, [www.nurturegroups.org](http://www.nurturegroups.org).

The Nurture Group Network has developed a four-day certificate course for teachers, learning support assistants and others involved with nurture groups, at the Universities of Cambridge, Leicester and London. This course is highly successful and has been attended by over 1,400 students. To generate income and to strengthen regional development, the Network, with accreditation from the University of Leicester, now offers the course to local education authorities in their own area.

The Network also publishes the *Boxall Profile Handbook*, (Bennathan and Boxall 1999). The Profile is a schedule that assesses need and suggests remedies and is widely recognised as a useful tool beyond the confines of selecting children for nurture group placement.

As well as promoting nurture groups and supporting its membership through training and information services, the Nurture Group Network also supports a rigorous research programme. In 1998, the DfES sponsored a research project into the effectiveness of the groups, led by Professor Paul Cooper of Leicester University. The main findings of the study indicate that nurture groups make a significant contribution to pupils' social, emotional, behavioural and academic development. Groups which had been in existence for two years or more at the commencement of the

project achieved statistically significant improvements in pupils' social, emotional and behavioural functioning after two terms, when compared with the progress of pupils with SEBD in the same mainstream schools. As previously stated, a further finding of the research was that nurture groups appear to contribute to the effectiveness of the schools as a whole. This was demonstrated by the fact that children in old and new (established for less than two years) nurture groups, as well as the matched children with SEBD in the mainstream of these schools, performed significantly better than pupils with SEBD attending schools without a nurture group.

Currently a research project is being written up to explore the views of parents of children in nurture groups and the impact that the group has made on the families' experience.

Although the locus of nurture groups is in schools, the model of intervention has relevance to the wellbeing of children across the diverse fields of education, social care, mental health services and youth justice. In an increasing number of instances local authorities are integrating nurture groups into their mainstream early years strategy and this is clearly to be welcomed. However, even with several hundred groups across the United Kingdom there are still ongoing issues of how to root nurture groups and a nurturing approach in policy developments at national and local levels. This is the ongoing work of the Nurture Group Network. For further information please contact:

#### **Jim Rose, July 2004**

Director, The Nurture Group Network, 307 Spitfire Studios, 63-71 Collier Street, London N1 9BE – 020 7833 9603 – jim.rose@nurturegroups.org

## **Key issues in Northern Ireland**

### **Northern Ireland Faculty of Child and Adolescent Psychiatry**

There are a number of issues particularly relevant to Northern Ireland child and adolescent psychiatrists at this time.

- The Regional Review of Mental Health and Learning Disability
- Recruitment and retention of child and adolescent psychiatrists.
- Adolescent inpatient services.

### **Background**

Northern Ireland has a total adult population in the region of 1.6 million (1,689,300) with a 0-19 year population 499,800 i.e. 29.6% of the total adult population; 24% of the population of Northern Ireland is under 16 years, compared to 20% in the UK.

Northern Ireland has an integrated Health and Social Services. Northern Ireland has been living with 'The Troubles' and its aftermath since 1969. Having had devolved government for a short period as a result of the Good Friday Agreement, direct rule was reinstated when this process collapsed. Since then there has been a political vacuum. The recent local elections saw the majority of the votes going to the two political parties at opposing ends of the sectarian divide, with the more middle ground political parties losing out.

### **CAMHS**

Northern Ireland is divided into four Health and Social Services Boards: Eastern, Northern, Southern and Western. Originally CAMHS was a regional service delivered by 2.5 WTE consultant psychiatrists and supporting staff operating from a department in a general children's hospital in Belfast, Northern Ireland's capital city. It is only since 1989 that teams/services started to be established in other Board areas. By 1992 a basic service was established in each of the four Boards. For a long number of years there was only one designated adolescent service and that was in Belfast in the Eastern Board. A core CAMHS team is considered to be a psychiatrist, nurse, psychologist and social worker. It is only in recent years that therapists such as family therapists and various forms of psychotherapists have been trained and are available in small numbers to recruit. However, generally there are few of these specialist posts being created. There are different age ranges for services.

### **Regional Review of Mental Health and Learning Disability**

Each of the Boards has at some stage done a review of CAMHS in its area but no regional overview of services or no attempts to plan strategically for the region have been successfully attempted until the setting up of the Regional Review of Mental Health and Learning Disability. This commenced in 2002 and is due to report in the spring/summer of 2005. It is a regional review covering law, policy and service provision. There are ten working sub-groups, of which one is a review of the Mental Health (N. I.) Order 1986. The review started with five of the sub-groups. The CAMHS sub-group is part of the second wave; it commenced work in September 2003. There is a process of consultation now nearing completion,

with written submissions being sought from a wide range of individuals and services. There are three sub-committees looking at Tiers 1-2, Tiers 3-4, and a social inclusion/marginalised youth group respectively. A human rights group is looking at the implications of human rights for CAMHS in Northern Ireland

The initial focus of the sub-group has been on managing transitions between CAMHS, adult, learning disability, alcohol and substance misuse services. Some of these other committees are a full year ahead in terms of review of their services and they already have written reports prepared. It is hoped that the initial draft report for the CAMHS sub-group will be available by October 2004, with a view to having a final report available for consultation in January 2005. The consultation on recommendations from the review of adult services is currently under way.

This review is seen as a unique opportunity to influence the future of CAMHS in Northern Ireland. The question remains whether the strategic focus is on providing an improved CAMHS or whether it is working to a 'modernisation' agenda with a view to providing a comprehensive CAMHS across all the Tiers. This has not been made explicit, as it has been in the rest of the UK.

#### **Recruitment and retention**

This is a major problem. There are 19 full-time WTE consultant posts on paper; however, there are only 14 consultants in permanent posts providing 10.7 WTE (this reduces to 10.5 WTE in summertime) of the actual service. Six consultants are aged over 47 years; 8.3 WTE vacant posts (40% vacancy rate approximately). In addition it is difficult to recruit locum cover for the vacant posts. A number of vacancies are new posts that have consistently failed to recruit.

There are eight specialist registrars in the province. To date a significant number of specialist registrars in training have been flexible or part-time trainees. The Specialist Advisory Committee for Psychiatry recommended (November 2003) an increase in SPR numbers to fourteen. However, there have been difficulties acting on this owing to a combination of lack of suitable applicants and lack of consultant trainers in the province. There are nine SHO posts, at least two of which are currently vacant. There is one staff grade post in the regional adolescent unit. Two other posts have received funding for community services; however, the latter two posts are instead of consultant expansion.

#### **In-patient services**

Currently there are two inpatient units - a regional adolescent inpatient unit with 16 beds and a regional children's unit 0-13years. This is a 20-

bedded unit with five day places and two family admission places. Both units are in Belfast in the Eastern Board.

#### **Adolescent**

The Department of Health and Social Services and Public Safety Report (2001) 'Commissioning In-Patient Psychiatric Services for Children and Young People in Northern Ireland' recommended that:

- There should be 26 adolescent in-patient beds, supported by an appropriate level of community infrastructure, including day hospitals.
- The beds should be split into two units, one in the East and the other in the West of the province.
- One should have a secure treatment capability

The Eastern Board 6-bed adolescent inpatient unit, initially set up in 1992, was targeted for development in line with the first phase of the Department of Health's recommendations. Commencing in 2002 it expanded over time to provide a regional inpatient psychiatric service with 16 beds. The second phase, with the establishment of a 10-bedded inpatient unit in the west of the province, was identified in the Department of Health's Priorities for Action 2003, but despite receiving bids from interested providers the process seems to have stalled, with no indication of what the Department's intentions are at this stage. Even if this was acted on, the resources in the west in terms of psychiatrists at both consultant and junior level are such that 24-hour rota cover for the unit would not be possible. There is also a lack of suitably trained nursing staff.

The transition from an EHSSB to a regional service is proving to be difficult. A lot of experienced staff moved to community services, leaving new and inexperienced staff to run the inpatient unit. There have been difficulties with staff recruitment, bed blocking, bed shortage and longstanding difficulties with the provision of 24-hour medical cover have worsened.

In the EHSSB area there is a chronic shortage of psychiatric beds for adult patients, which means that it is almost impossible to get acutely mentally ill adolescents admitted. In other Board areas adolescents can get admitted to adult psychiatric hospitals, and while this is helpful in solving the acute safety issue, it is still an inappropriate environment.

#### **Children's 0-13 years unit**

The regional children's unit, having struggled to deal with deficits in nursing staff numbers and morale issues, is currently in crisis. This has been precipitated by the fact that the full-time consultant has left to take up another post. There is no

replacement and there are difficulties with psychiatric cover. The unit was effectively closed for admissions for a couple of months. Recently, sessional input from two locum consultants has allowed the unit to open for planned admissions with a reduced bed capacity (10 beds). Emergency admissions are not being accepted at this stage.

There are no day places available in the province apart from the minimal numbers linked to both regional units in the Eastern Board area.

### **Snapshot of other developments:**

#### **CAMHS manager**

Appointment of a CAMHS manager in one Board has led to significant improvements in service delivery, with a phased implementation of the Boards CAMHS strategic plan.

#### **Psychotherapy training**

A small group of child and adolescent psychiatrists assessed the need for and interest in developing training in psychodynamic psychotherapy. Dr Judith Trowell was consulted and with her assistance we developed a psychotherapy course. The course is modelled on the M14 Tavistock course 'Psychodynamic Psychotherapy for Child and Adolescent Psychiatrists'. The course commenced in September 2002. It involves:

- Theory module on child/personality development and psychoanalytical theory
- Infant observation module
- Clinical module with supervised psychotherapy cases and two hours per week of personal analysis

A psychotherapy conference programme will support the training. This was launched with a regional conference on 'Working Therapeutically with Looked After Young People', in May 2004.

#### **Research**

There is ongoing research in the area of early onset psychosis. Currently an assessment of need in relation to hearing-impaired young people, and the services available to them, is being undertaken in association with the National Deaf Children's Society.

#### **The future?**

Northern Ireland has tended to lag behind the rest of the UK in terms of implementation of government initiatives. This can have advantages, as we can learn from the experiences of others. We hope to continue to do this. Containing our anxieties and upholding the morale of our Faculty as we continue to work towards improvements is our aim. Our hope is that Northern Ireland doesn't

lags so far behind that the knowledge gained is only academic.

We are interested in the Scottish Faculty's approach to mentoring, where all consultants have opted for mentoring, with reported improvements in morale. With the small pool of consultants in Northern Ireland, some thought is being given to the possibilities of linking up with other jurisdictions to host joint meetings.

**Dr Anne Murray 22<sup>nd</sup> July 2004**

### **Conferences**

High-risk and offending conduct in individuals with learning and developmental disability, who are severely and personality disordered: 17<sup>th</sup> September, 2004, School of Medicine, University of East Anglia Camus, Norwich.

Atypical gender identity development: combating stigma and the provision of clinical services: 12<sup>th</sup> and 13<sup>th</sup> November, 2004, Tavistock Centre, London.

Pathways to permanency: the annual fostering and adoption conference: 26<sup>th</sup> November, 2004, Tavistock Centre, London.

Faculty CPD Institute: 21<sup>st</sup> January, 2005, Royal College of Obstetricians and Gynaecologists, London.

College annual meeting: 20<sup>th</sup> – 23<sup>rd</sup> June, 2005, Edinburgh International Conference Centre.

Faculty residential meeting: 21<sup>st</sup> – 23<sup>rd</sup> September, 2005, Harrogate International Centre

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# **The End**

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