Faculty of Child & Adolescent Psychiatry Executive Committee Newsletter

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In this issue

Joanne Wallace (ST2 CAMHS Run Through Trainee Rep) and Hetal Acharya (ST6 CAMHS Higher Trainee Rep)

Welcome to the summer edition of the newsletter. As the guest editors of the CAP newsletter, we would like to wish Louise Theodosiou a speedy recovery from her recent surgery, her work as editor over the years has been invaluable to the Faculty and has helped spread awareness of the wonderful work our members are doing. Our summer issue includes the prize-winning essays for the Harrington prize and also the Medical Student Essay prize. Entries are open for 2023 entries, hopefully some of our readers will be inspired to take part. We also have updates from our research networks including a literature review on the use of Clozapine in CAMHS, ecoCAMHS work streams on sustainability in CAMHS and also the Paediatric Liaison network reporting their survey on training in this area. We also have reports from the Annual RCPsych Wales Primary Schools Mental health debate which one of our trainee reps was able to attend and also a report on the use of "experts by experience" in service development, hopefully you can see how the college is engaging with young people in a wide variety of ways to promote mental health awareness and the development of services. As our Chair tells us in her update the college is also supporting the continued expansion of the CAMHS workforce, it was a pleasure to also include work by our colleagues in organising a summer school for young people interested mental health careers. Thanks so much to everyone who has contributed to the summer edition.

It has been a pleasure to edit this edition of the newsletter. I'm sure you will agree that the variety and quality of work is wonderful. Please send in submissions to be included in future editions to Catherine.langley@rcpsych.ac.uk

Contents

The Chair's column

Elaine Lockhart

I am writing this on another splendid day of sunshine and heat but am fully aware that we have had further evidence, if needed, of our heating planet and the impact of climate change on the population's health, livelihoods and living conditions. Our Eco-CAMHS group has been very active, and you will be hearing more from them about their 10 Top Tips later in the year.

A highlight of the year so far was the face-to-face Faculty's strategy day which took place in June. It was such a pleasure to meet colleagues after a long time of online meetings and we had very productive, lively small group discussions to help inform our update to "Building and Sustaining Specialist CAMHS" and "When to see a child and adolescent psychiatrist" and our Retention and Recruitment strategy. I am hoping that you will be hearing about these reports as they are being developed through your networks and we would welcome your input.

Workforce continues to be high on our agenda and we have been working with the College Officers, NHS England, Health Education England, and others to continue to make the case for increased funding of specialist CAMHS services and in particular for additional psychiatric higher training numbers around the UK. With recruitment to core training posts at 100% for the 3rd year running and 80% of our higher training posts filled (up from 45% four years ago) we are making progress, but with the increased demands on our services and a consultant vacancy rate of 14%, we will need to continue to improve on this. We need help from our consultant and SAS doctors to provide high quality training placements and opportunities, not just for our higher trainees, but also for other medical trainees e.g. paediatric and GP colleagues. This will help develop the number of clinicians who can offer effective assessments, diagnoses and interventions for infants, children and young people with neurodevelopmental and mental health disorders. If you are not already a trainer for core trainees and/or higher trainees, please do contact your local Training Programme Director to find out what this entails. We can only argue for more training numbers when we are filling vacant posts and all the work that you are doing with school pupils, medical students and trainee doctors to encourage recruitment is more vital than ever.

Regional reps play a very important role in England and Wales to support consultant appointments and to bring us intelligence about our specialty across the countries. There are vacancies for regional reps who are part of our Executive committee, and I would encourage you to find out who yours might be and, if there is a vacancy, to consider applying. More information can be obtained either

from your local College Division team or be contacting us at the College. We hope to be able to offer a free place at our annual conference for all regional reps, so please get in touch!

I was delighted to attend the annual conference of the Royal College of Paediatrics and Child Health and contribute to the debate about mental health. There has been a developing understanding of their role in this area, especially when they have been seeing an upsurge in the number of unwell children on their wards. NHS England has been working collaboratively to develop training for paediatric colleagues, as well as providing funding to test how we can improve mental healthcare provision in acute healthcare settings. It was sobering to hear that the leading cause of death is now suicide in children over 5 years. This reflects the great progress made in the treatment of physical health conditions and we are continuing to lobby for the same focus and funding for mental health conditions.

Integrated Care Boards have been established in England, which as in other parts of the UK, offer the prize of integrated working across services and agencies for their communities' benefit. Each will have leads for mental health and for children, who can be contacted to ensure that children's mental health is being considered within this new system. Funding has been released across England to target health inequalities which would be well used to target mental health difficulties at the earliest stage, both chronologically and at the onset of illness. The College's recently launched Public Mental Health Implementation Centre has, for obvious reasons, identified children and young people as an area of priority. Their focus will be on the implementation gap between research and service delivery and how to deliver better outcomes.

There has been further work within the College for the 0 – 25's, with a position paper being worked up for the 0 – 5's and the first meeting held about young adults, which is being co-chaired between the General Adult Psychiatry Faculty and ourselves. This will build on the 0 – 25's paper which sets out the challenges for young people who should be able to make a seamless transition between CAMHS and adult mental health services, describes different models and makes the case for increased investment to make this happen safely and to allow adult mental health services to offer developmentally appropriate and accessible services for 18 – 24-year-olds. There will be implications for training for this age group, as well as for the under 5's, which will be taken forward within the College along with other organisations.

There will be an Extraordinary General Meeting of the College on the evening of the 8th September which can only, for legal purposes, be held face to face (although it can be viewed online). There are options to attend this in Belfast, Birmingham, Cardiff, Edinburgh, Exeter, Leeds, Ipswich and Newcastle. I realise that it could be difficult for members to go to this after a busy day but, if possible, it would be great to have as many colleagues as possible attending and using their vote. There will be 2 proposals which, if supported, would allow College Affiliates (mostly SAS doctors) to have the right to vote within the College and to allow for future AGMs to be held online. I have to confess that up to recently, I hadn't realised that our SAS doctors didn't have voting rights and I will certainly be supporting this, as well as having the opportunity for online AGMs, both of which would, in my view, make it easier for colleagues to contribute to and influence the work of the College.

You may have seen the unacceptable language used in promotion of a College CPD event regarding Personality Disorder. There was an instant apology from the College with an immediate change of internal processes and this is being taken up as a call to challenge stigma and therapeutic pessimism within our colleagues regarding people with this diagnosis. It is timely that colleagues within our Faculty, along with experts with experience, are developing a position paper in this area which will

set out the best evidence base for the use of the diagnosis and treatment for young people with personality disorder.

Colleagues have delivered a training programme for psychiatrists in Ghana about CAMHS which was at their request via the College's international team. This will be evaluated and the learning will be taken forward which could be used in other countries, if it meets local needs.

We have been involved in meetings with NHS England, the British Paediatric Neurology Association, and the charity PANS/PANDAS to develop a consensus on the best evidence-based treatment for children who meet the criteria for these disorders. I would be interested to hear from any colleagues with experience of working in this area to gather thoughts about how services can respond helpfully to this group, in the absence of a robust evidence base to date.

We have also been contacted by the Cass review about the closure of the Tavistock Gender Identity clinic for children and young people, with the proposal to develop regional services. These will be paediatric-led, but the teams will be multi-disciplinary and there will be a need for access to specialist CAMHS where there are co-morbid neurodevelopmental and mental health disorders.

All the work described has involved the work of many excellent colleagues, both on the Exec committee and within the wider Faculty and I am hugely grateful for their generosity with their time and expertise.

It's been a busy time for us all and I hope that over the summer you will all have the chance to take a proper break and return refreshed and ready for the autumn term. I look forward to seeing many of you online at our annual conference and AGM at the end of September.

Dr Elaine Lockhart
Chair, Faculty of Child & Adolescent Psychiatry
@DrElaineLockha1
c/o Catherine.langley@rcpsych.ac.uk

Report from Northern Ireland

Siona Hurley

Hello from Northern Ireland and I hope you are all enjoying an opportunity for some rest and relaxation during these summer months. Of course, the work of the Faculty continues at pace here in Northern Ireland as I'm sure it does across the Nation, during the summer as in the rest of the year. The first news that I have to share is the sad news that Dr Mark Rodgers has decided to stand down as Chair of the College for Northern Ireland; on behalf of all members of the college locally I

would like to extend thanks to Dr Rodgers for all of his hard work on behalf of the College during his 3 years as Chair. I have no doubt that Mark will remain an active and valued member of the local Faculty. That leads me on to the happy news that Dr Holly Greer has been appointed as the new Chair, I am delighted to offer my congratulations and I look forward to working with Holly for the remainder of my time as Vice-Chair.

Dr Phil Anderson recently had his article published regarding the Minimal Age of Criminal Responsibility - Why it Should be Raised in Northern Ireland. An excellent article raising many salient points on why the current MACR of 10yrs should urgently be reviewed by the Northern Ireland Executive.
http://qpol.qub.ac.uk/minimum-age-of-criminal-responsibility-macr-why-it-should-be-raised-in-northern-ireland/

The NI Mental Health Workforce Review, being carried out by Ernst & Young continues with Dr Anna McGovern representing CAMHS. It is hoped that this review will demonstrate the need for expansion of our teams across the region, as we all struggle to meet the current and rising demand.

Upcoming events: RCPsych NI Research & Audit Day Draft Programme Wednesday 5 October 2022 | 12.30pm to 7pm Andrews Gallery – Titanic Belfast

Report from Scotland

Helen Smith

The Scottish CAMHS Faculty continues to be very active. We have responded to the Scott Review of mental health law in detail. We have contributed to the proposals for the National Care Service in Scotland. The CAMHS Faculty in Scotland is pushing forward with developmental of community pathways for young people with Borderline Personality Disorder and contributing to the national college position statement on this issue. We welcomed a new vice chair: Dr Kandarp Joshi will be a valuable addition to the CAMHS executive committee. The Faculty is looking forward to its conference in November 2022 where the AGM will occur. We would welcome all members to the meeting.

c/o Catherine.Langley@rcpsych.ac.uk

Newsletter from Wales

Dr Amani Hassan
Mr Ollie John, RCPsych Manager in Wales

Summer is here, Winter has passed and maybe we find a new start
"Eric Gadd"

Greetings from the Faculty of Child and Adolescent Psychiatry Wales,

The Faculty hosted a joint conference with the General Adult Faculty on the theme of transitions from child to adult services in June. The event was chaired by Dr Amani Hassan, and we heard presentations from Mind Cymru; Dr Dave Williams gave an update from Welsh Government on managing crisis in transitions; Dr Balakrishna gave an update from RCPsych 0 – 25 steering group; whilst Dr Surekha Tuohy, Clinical Lead for Community Paediatrics at SBUHB, presented on Guidance, models and implementation in transitions.

We welcomed £12 million pound of new investment into Neurodevelopmental services in Wales. This investment has been informed by 2 recent Senedd debates (on Tourette's, and on neurodivergent conditions) that we were heavily referenced within, as well as a demand and capacity review that received consultation responses from our membership. Dr Amani Hassan wrote an article for The National in advance of the debate on Tourette's, calling for a clinical pathway in Wales, and in support of a public petition.

A video has been produced on the work of TERMS (Technology Enabled Remote Monitoring in Schools), we are a partner in the project; whilst a funding submission on the next stage of the project has been developed.

Dr Kathryn Speedy presented with Poppy Stowell-Evans (Chair, Youth Climate Ambassadors Wales) at the Green Health Wales Conference. The topic of the presentation was Climate Change and Mental Health and had reference to the College's work. The event further showcased a number of sustainability and mental health projects in Wales.

This year, two of the three RCPsych Wales policy and public affairs attachment posts are trainees in CAMHS, Dr Megan Davies-Kabir, and Dr Darchana Patel. They are both underway with projects, and we will be keen to update the Faculty on progress and the good work they are already undertaking.

We hosted our first RCPsych Wales Summer School, the pilot event was held in partnership with TEC Cymru and was supported by the Senedd. It was designed to give young people interested in mental health-based careers an insight into the different paths available. The first day saw the participants

meet with a variety of mental health professionals, including presentations from Dr Katherine Speedy and Dr Elaine Lockhart. Day two was based in the Senedd and looked at how government policy is created and scrutinised, and how it can be informed and influenced by those working in the mental health sector. The young people met with Sarah Murphy MS who spoke about the work she had been undertaking to advance the development of a specialist eating disorder unit in Wales. We'd like to extend thanks to Prof Alka Ahuja and Gemma Johns from TEC Cymru, Ollie John and Annie Fabian from RCPsych Wales, our management attachment Dr Jo Doherty, and to all our contributors for all the support in organising and facilitating.

Wales has started active steps to establish children and young people's liaison service in Hospital. The first workshop was held in April, organised by the Faculty of Liaison psychiatry, RCPsych Wales, and with the support of the child Faculty RCPsych Wales, and colleagues from the rest of the UK. The workshop was hosted by Welsh assembly Government (WAG). A series of workshops is planned to take place for the work to develop further. The aim is for the children and young people future service to have or achieve the same standards of the adult liaison service

- c/o Catherine.Langley@rcpsych.ac.uk

Child and Adolescent Faculty and Executive Newsletter – Trainees report

Sophia Williams, Hetal Acharya and Joanne Wallace



Hello Everyone!

It has been an interesting time in the world of CAMHS and in this summer newsletter we hope to provide you with some brief updates that may be of particular relevance to trainees.

First and foremost, we are so incredibly impressed with the quality of medical students' essays that were entered for this year's competition. For those of you who may not be aware, the college sets two essay questions annually, one for medical students and one for trainees. This year we had the wonderful opportunity to mark the medical student entries, the topic being on the impact of social media on child and adolescent mental health. It was a truly humbling experience, and we feel proud to say that tomorrow's doctors are a thoughtful and wonderfully reflective group. Please do look out for the winner who will be invited to this year's CAP Faculty conference!

We also have some exciting news, the CAMHS Trainee Conference planning has begun! This year we are bringing to you an ambitious line up, with themes from current topical issues, exploring career development options and even an opportunity for you to write up an article for our next newsletter. There will also be opportunities for networking and even a little bit of yoga! Keep your eyes peeled and we can't wait to see you all there.

We are also pleased to announce that a National Dual Trainee Network has been established after talks around differing dual training needs and a lack of existing networks. If you are interested in being a part of the dual trainee network – please contact Dr Mary Barret (mary.barrett1@nhs.net) and if you are a CAMHS/ID dual trainee, please contact Dr Sukhmeet Singh (singhsu@nhs.scot). I hope this has a positive impact on your training experience.

Finally, as many of you are aware, a new RCPsych Curricula has been launched this year. All trainees will move onto the new curricula by August 2024. Here, I have shared a link to all the information about the new curricula and I encourage all new trainees to take a look.

https://www.rcpsych.ac.uk/training/curricula-and-guidance/curricula-implementation

If you have any feedback on the curriculum, please do get in touch and we can forward it onto the relevant body.

Thank you and see you all at the conference!

Dr Hetal Acharya (ST6 CAMHS Higher Trainee Rep)

Dr Joanne Wallace (ST2 CAMHS Run Through Trainee Rep)

Dr Sophia Williams (ST5 CAMHS Higher Trainee Rep)

Harrington Prize Winner 2022

Dr Sewanu Awhangansi

The role of social psychiatry within present-day child and adolescent mental health

Introduction

"It takes a village to raise a child" (popular proverb)

For a moment, let us imagine a world where every child feels safe and have their basic needs met. A world where all children can grow up in loving and caring homes where their physical, emotional, and social needs are adequately met. Nurturing homes, void of the wide array of neglect, abuse and trauma that have become commonplace today. A world that provides every child with the opportunity to go to school to learn and grow. A world where the four walls of schools guarantee the safety and protection that is duly their right and not a gift. Schools where playgrounds and corridors are totally void of bullying and peer victimization and where children really want to be, not having to worry about the next school shooting. A world where poverty and social inequalities don't exist; where streets are safe from knife crimes and violence and all sorts of discrimination that we are now so accustomed to. A world where children no longer hide behind digital screens isolated, but where the value of community, building positive relationships and appropriate social interactions are entrenched. A world where children learn to respect other people, irrespective of the race, religion,

orientation, or background. A world without war, where peace reign supreme in all corners, and children don't have to worry about being internally displaced or being a refugee in a foreign land. A world where adults take responsibility and immediate action for the ecological crises, so that their children and their children's children don't have to worry if they will have a world to live in when they grow up.

The reality is that unfortunately this is a parallel world, far removed from the world as we currently know it. All these socio-cultural issues and more make our world unideal for children and young people to grow and fully maximise their potentials. As long as they exist, there will be a place and even increasing roles for social psychiatry.

Social psychiatry, according to the Merriam-Webster dictionary (1), "is a branch of psychiatry that deals in collaboration with related specialties (as sociology and anthropology) with the influence of social and cultural factors on the causation, course, and outcome of mental illness."

This essay explores the role of social psychiatry within present-day child and adolescent mental health. It starts by describing the burden of the issues, why social psychiatry is relevant and how it situates within current framework of psychiatry as a medical specialty as well as within child and adolescent mental health services. It thereafter described some of the roles of social psychiatry as it pertains to the "causation", course, and outcome of childhood mental health problems. Some suggestions for expanding the reach and impact of social psychiatry were subsequently offered.

Burden of the issue

The history of child psychiatry is intricately linked with good understanding of child development and in-depth appreciation of the role of family, culture, child-rearing practices and the place of a child within society. Unfortunately, the rapid growth of the biomedical model of illness and intervention over the last 100 years have pushed the field of social psychiatry further behind (2).

Children are considered the most physically, economically, and socially vulnerable population group. Currently, children and adolescents under the age of 18 constitute almost 50% of the population of the developing world and about 21% of the first world countries (3). Over the last three years, the likelihood of young people having a mental health problem has increased by 50%, with 1 in 6 children aged 5 to 16 reported to have a mental health problem (4). According to a World Health Organisation (WHO) report on adolescent mental health, there are significant consequences that extends into adulthood when these issues are not addressed promptly enough. For instance, mental health problems that start in childhood cause significant impairments in various life domains such a s family, education, work, quality of life (5) as well as high direct and indirect economic costs for society (6).

With mounting empirical evidence about the social determinants of child and adolescent mental health and the slowly increasing interests in the public health aspects of psychiatry (7), there is sense of hope about the opportunities that social psychiatry will offer the field and the varied roles it will afford everyone working directly with children and adolescents, including parents, education, health and social care professionals as well as those indirectly involved like government, non-governmental bodies, print and digital media and so on. Some of these roles are discussed below.

Social psychiatry and causation of childhood mental health problems

Despite the current limited knowledge about "causation" of childhood mental illnesses, genetic and environmental factors have been implicated with increasing evidence showing that environmental factors contribute significantly more to the risks. Social psychiatry therefore has a role in helping to

expand our current understanding about how and when these environmental factors take effect. For instance, some of the environmental factors that have been associated with childhood mental illness include in utero exposure to infection, lack of nutrients, maternal stress, perinatal complications, social disadvantage, urban upbringing, ethnic minority status, childhood maltreatment, bullying, traumatic events, etc (8). More investment in social psychiatry research therefore holds the key to helping us understand how to mitigate the impact of these factors.

Social psychiatry and course of childhood mental health problems

According to the World Health Organization, the social determinants of mental health are the conditions in which we "are born, grow, live, work and age," which are largely a reflection of socio-economic status and access to resources like health, education, gainful employment, and safe environment. Poverty and sociodemographic disadvantage have been consistently linked with poor mental health outcomes and persistence of childhood mental health issues into adulthood (9). These have also been associated with restricted access to high-quality mental health services, especially in climes where out-of-pocket payment is required (10). Social psychiatry can provide outreach services as well as play a collaborative role in working with government, health and social services, charities, non-governmental organisations, and other relevant agencies in developing models of child mental health care that is affordable and accessible to disadvantaged children and families with mental health needs.

Social psychiatry and outcome of childhood mental health problems

Childhood behavioural and mental health issues are associated with a wide range of adverse psychosocial outcomes in later life, for the individual and their families, as well as unquantifiable cost on society. Children and adolescents with conduct and disruptive behavioural problems have an increased risk of dropping out of school, having fewer academic qualifications, and being unemployed as adults. This underachievement keeps them at a disadvantage with their peers and may likely fuel more antisocial behaviours that will put them at risk of conflict with the law (11). Many of these children would have had troubled and traumatic childhood. Social psychiatry can be involved in the early identification of children with these patterns of behaviour and providing bespoke early intervention packages in the community. The success of any involvement will rely largely on effective multiagency workings with education, health, and social care as well as with the youth criminal justice system. Early identification of the emotional and social needs of these children, appropriately addressing the needs and supporting them through education (mainstream or special needs) is more likely to reduce the risk of adverse psychosocial outcomes.

Social psychiatry and the Sustainable Development Goals (SDG)

The peculiar role of social psychiatry in child and adolescent mental health is further brought to the fore by the SDGs adopted by all United Nations member states in 2015 which provides a blueprint to achieve a better and more sustainable future for all by 2030. All the 17 SDGs addresses different social, environmental, and political issues that directly or indirectly impact on the mental health of all people of the world, especially the children and adolescent group. For instance, poverty, hunger, education, clean water and sanitation, employment, inequality, and world peace are various social issues that have far-reaching effect on the predisposition, precipitation, and perpetuation of childhood mental health problems. The role of social psychiatry can therefore be to explore avenues on how to transform all these issues into protective factors that can boost and strengthen mental health resilience in children and adolescents. In particular, SDG3 seeks to reduce maternal mortality, end all preventable deaths under five years of age, reduce mortality from non-communicable

diseases and promote mental health, prevent and treat substance abuse and also achieve universal health coverage for all (12). There are therefore numerous opportunities for multidisciplinary and intersectoral collaborations that would involve social psychiatry.

Social psychiatry and climate change

There is established evidence about the threat to human health that climate change and ecological crises pose (13). However, their attribution to specific mental health outcomes, especially in children, remains challenging. This creates ample opportunities for those in social physiatry to advance the field through empirical research. Through their expanding knowledge and understanding of the environmental impact of climate change, they can gradually take up active roles as campaigners and advocates of a greener and more eco-friendly world. As experts in the field, they can be directly involved in translating evidence from research into policy decisions and then subsequently into everyday practice. Social psychiatry experts will be well placed to encourage colleagues to strongly recommend ecotherapy or green therapy as part of routine clinical practice.

Social psychiatry and child displacement

With more than 33 million children who have become refugees or been forcibly displaced all over the world (14), there are numerous opportunities for social psychiatry in this population group. Every child deserves the opportunity to grow in a safe and protected environment, where they can maximise their potential to become heathy, productive citizens of the world. The opportunity to achieve this is extremely limited for children who have been displaced or who are living as refugees. The direct and indirect impact of the childhood trauma on their mental health is unquantifiable. As such, social psychiatrists can serve roles including being on-site to provide supportive counselling, therapy, and other necessary treatments, including medication. They can also help to ensure that the rights of this vulnerable group are protected, especially in the countries they are seeking asylum. The social psychiatrists can also serve role as campaigners and advocates for world peace by collaborating with relevant groups.

Recommendations

As already discussed, there are lots of roles for social psychiatry in current day child and adolescent mental health. While it may be difficult, time and resource-consuming to set up separate social psychiatry units across local and national health services across the UK and other countries of the world, it may be smarter to use an integrative approach where the principles of social psychiatry are gradually integrated into existing health, education, and social care structures (15). This is more likely to yield faster and widespread uptake. The Royal College of Psychiatrists statement on Social Prescribing (16) support this approach and is step in the right direction.

Other suggestions to expand uptake of social psychiatry in child and adolescent mental health settings include:

Child and adolescent mental health professionals to place increasing emphasis on the social component of the bio-psycho-social model as it relates to prevention, investigation and intervention of mental health issues.

Clinicians to be encouraged to use the Z codes (ICD-10) or the V codes (DSM 5) more in their formulation of young people's diagnoses and management framework, as these help to clearly highlight some of the socio-cultural issues peculiar to each young person in their care.

More than just multidisciplinary team workings, professionals working with children and young people to inculcate multiagency collaborative approaches in their practice.

Undergraduate medical curriculum should put as much emphasis on the importance of the social determinants of child mental health, as is done with the biomedical model.

Encourage more funding and more people to participate in social psychiatry research. Support platform where research evidence can be translated to policy and practice.

Conclusion

If we take another moment to imagine the reality of our current world, we may become overwhelmed by how far from ideal it is for normal child mental health development. However, if we collectively start doing the simple things like enabling families to provide nurturing homes, making schools safe and building a sense of community in society, this "ideal" world becomes increasingly realizable. Social psychiatry has a huge role to play in achieving this world and all hands need to be on deck.

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Harrington Writing Prize 2023

The 2023 iteration of the prize has now opened. The topic will be ***The role of CAMHS in gender identity services.***

This competition is open to core trainees, specialty trainees and specialty doctors in the United Kingdom. For further information please see the Faculty website.

Prize: The winner will receive £100 and a certificate. The winning essay will be published on the Faculty webpage. The Faculty executive committee will work with the winner to explore additional publication options.

Deadline: 24 March 2023

Medical Student Essay Prize 2022

Liam Vandewalle

Social Media – a help or a hindrance? Discuss the evidence regarding the impact of social media on the mental health of children and young people, illustrating with a case example.

Introduction

The links between social media (SM) and young persons' mental health (YPMH) have been the subject of discussion in both public and academic spheres since SM began its ascension to prominence in 2007[1]. SM's cost-free pricing structure, ease of access and potential for rapid communication have resulted in widespread uptake which has seen SM become pervasive in today's world. Recent statistics reveal that 87% of children aged 12-15 have a SM profile in the UK[2] and statistics from the United States show that children under two are spending an average of 42 minutes on SM a day and 45% of adolescents are online 'almost constantly'[3]. Alongside this growth there has been a decline in YPMH, with suicide rates amongst young people (YP) aged 10-24 increased by 56% between 2007 and 2017[4]. When considering these respectively formidable and harrowing numbers there is the crucial question of whether the uptake of SM has been contributing to declining YPMH. The public discourse suggests there is a link, with many alleging negative effects on their own or others' mental health, but are these accounts sufficient for mental health professionals to resolutely state that the decline of YPMH is even somewhat attributable to SM use? Adding further complexity is a strong voice from YP, parents, teachers and doctors who attest that SM is positively contributing to YPMH and that it has formed a cornerstone of many YP's wellbeing. Herein lies the question which is at the core of this essay: is social media a help or a hindrance when

it comes to YPMH? The implications of the answer to this question are of a magnitude that is hard to overstate, considering SM's aforementioned ubiquity and influence.

What is 'Social Media'?

As the term 'social media' can refer to a range of apps and sites which call forth an array of different responses depending on who is referring to and interpreting it, a working definition of the term is necessary for the purposes of this essay. The definition presented below draws on a number of appreciable sources and is both precise yet appropriately general in scope:

"Broadly, social media is defined as any digital tools or applications that allow users to interact socially, and can be distinguished from traditional media (e.g., television) by the fact that users can both consume and create content. Under this broad definition, "social media" may include social networking sites (e.g., Instagram, Snapchat, Facebook, TikTok), text messaging and messaging apps, social gaming tools, YouTube, and more." [5]

This kind of objective definition is the only one which is appropriate at this point in the discussion. Any further attempts to add nuance require a more in depth exploration of the issues behind defining a concept which has numerous iterations which are then used uniquely by billions of individuals. This definition touches upon this important fact and recognises that SM is a heterogenous term with manifold manifestations, which is in turn part of the reason behind the infamy surrounding defining SM in the literature[6]. The development of the concept of SM using more nuanced but subjective perspectives is discussed below.

Public Views of Social Media and its Impact on Mental Health

Before examining how SM is perceived and evaluated in the academic literature, it is worthwhile examining in some detail the attitudes towards SM as well as its implications for mental health from the point of view of the layperson. According to Dahlgreen & Whitehead, cultural attitudes can play an important role in physical as well psychological illness by consciously or subconsciously guiding interactions with a specific health- or disease-promoting entity[7]. As such, public ideas surrounding SM are worth bearing in mind during the reading of this essay. Some news articles from which the public sentiment toward SM can be derived include headlines such as "Social media is harming the mental health of teenagers. The state has to act"[8], "Social media damages teenagers' mental health, report says"[9] and "Step away from the smartphone: Just two minutes of 'doomscrolling' through social media can bring your mood down, study warns"[10]. These articles are examples of common media portrayals of how SM relates to YPMH; using these portrayals as well as relevant qualitative research[11,12], the following subjective conclusions about public perceptions of SM impact on YPMH can be drawn:

There is a belief that as SM use increases for a given individual, mental health deteriorates.

The most commonly purported mechanism explaining the statement 1 resembles what is referred to in the literature as 'social comparison theory'[13].

There are views that social media usage positively correlates with behavioural disorders such as ADHD.

There is a recognition that SM can be a useful tool in socialising, education and creative pursuits.

There are a subset of YP who benefit from SM use. It is important to bear this cultural backdrop in mind when exploring the following academic literature. It is also worth questioning whether some or all authors may have, knowingly or otherwise, been influenced by these overarching narratives.

Introduction to Literature Review

The existing body of literature attempting to investigate SM's role in detracting from or promoting YPMH is vast and examines multiple facets of a heterogenous entity, the problems around defining which have already been highlighted. Based on the literature, I have concluded that the most appropriate answer to the original question is that SM is both a help and a hindrance in promoting YPMH. I will present the research for each of these seemingly dichotomous descriptors in order to

demonstrate that SM has highly variable effects on YPMH. I will then offer an albeit limited explanation of this apparent paradox by presenting literature which points towards two related but distinct variables upon which the effects of SM on YPMH hinge: the YP themselves and how that YP interacts with SM. By presenting the literature in this format, I aim to demonstrate to the reader that there are a series of factors at play which dynamically influence each other, and which then produce either a healthy, beneficial relationship with SM, or a pathological, destructive relationship with it. I will then continue to highlight themes from the literature that exist above or outside the points already discussed. Finally, I will look at the impact of SM-related psychopathology on third-party stakeholders by looking at its indirect effects on family dynamics, educational environments and in inpatient psychiatric wards.

A Help or a Hindrance?

A Help: The Positive Effects of social media on Young Persons' Mental Health

SM is correlated with improved well-being and lower levels of psychological distress[14,15,16,17]. One of the main voices from this side of the argument is that which hails the connection that SM provides. Indeed, one study showed that 81% of adolescents have reported an increased sense of connectedness with their friends via the medium of SM[18]. Another study showed that SM used to connect with family and friends positively impacts mental health, as it is seen as a way of finding meaning and acceptance[19]. Additionally, YP report a feeling of increased freedom to choose entertainment, modes of creative self-expression and methods to foster identity formation[20], all of which are widely considered to positively impact mental state. This narrative has only grown during and in the light of the COVID-19 pandemic, during which YP were forced to derive social fulfillment mostly via SM platforms. This has led to a consolidation of SM's boons and benefits in the realm of peer-to-peer interaction[21], the results of which are still to be fully appreciated.

Building on the above, YP who belong to certain minority groups or have specific physical or psychiatric diagnoses have found a sense of understanding and connection through SM with others who belong to that group. For example, LGBT+ YP are more likely than their non-minority counterparts to befriend other similarly identifying peers online and see them as a valuable source of support[22]. This support very likely plays a protective role for YP with mental health issues. A final set of potential benefits of SM use comes from a technology-based potential within applications and websites. Research has been performed to examine the degree to which signs of depression, suicidal ideation & substance abuse can be detected from user behaviour through machine learning, with the potential of increasing positive or sign-posting content to support the YP[23].

A Hindrance: The Negative Impact of SM on Young Persons' Mental Health

The majority of literature available on SM's impact on YPMH has focused on the psychopathologies associated with its use. The research presented below looks at both the 'direct' and 'indirect' mechanisms through which SM exerts negative effects on YPMH. Commentaries looking at direct correlations (i.e., features implicit within SM which have a negative correlation with YPMH) hinge on the idea of 'social comparison theory'[13]. Social comparison theory offers the idea that there is a tendency for content creators to use SM to create an online reconstruction of their lives which skews towards portraying themselves as unrealistically care-free, well-off and happy. The consumption of these carefully crafted reconstructions by YP leads to negative social comparisons between themselves and their peers, according to social comparison theory. This casts the YP's own accomplishments, attributes and general life situation in a relatively negative light and subsequently imparts feelings of inadequacy and envy. Higher levels of social comparison have been found to be correlated with depression[24] and damaging beliefs specifically centering around body image have also been correlated with peer-based social comparison as well as celebrity comparisons (itself termed 'upward social comparison')[25]. A second narrative in the literature is the association between SM use and behavioural disorders such conduct disorder (CD)[27,28] and attention deficit hyperactivity disorder (ADHD)[28], and personality disorders such as antisocial personality disorder (ASPD)[29]. It

should however be noted that the nature of these associations is dubious and as such will be explored later in the essay.
Conversely, indirect effects of SM look at the ways it acts as a vehicle through which external risk factors for worsened mental health are engendered. For example, cybervictimization received through SM is correlated with higher levels of self-harm and suicide[30,31], and since its inception SM has been used increasingly as a conduit through which cyberbullying is perpetrated. Further to this, cyberbullying has also been found to lead to higher levels of both internal and externalizing behaviours[32]. Another indirect mode of influence is increased exposure to peers who display, share and/or encourage risky behaviour online, for example alcohol and illicit substance consumption[33]. Similarly, some studies have found that access to content relating to self-harm and suicide may increase the risk of these amongst vulnerable YP[34].
A final yet crucial mechanism through which SM may damage mental health is that of 'displacement'. This relates to how phone screens and SM use affect sleep patterns (duration, quality, daytime sleepiness), and circadian rhythm[24,35]. Considering the importance of sleep for the adolescent brain, this is yet another mechanism through which SM use could negatively influence YPMH. Kostyrka-Allchorne et al.[36] went some way in addressing the question of displacement, asking whether screentime (but not SM use) itself imparts behavioural disruption, or whether it is the opportunity cost of not participating in offline activities. The study concluded that there was no evidence that displacement of offline recreation by time spent on a screen was a significant concern, suggesting that it is perhaps something implicit within the screen use itself.

Identifying Those At Risk: Variables Mediating Social Media Impact

The Young Person - The Role of Personal & Social Factors

Seeing as individual factors are crucial in understanding offline addictive and/or problematic behaviours, it is worth considering whether YP's personal traits and social milieus affect their susceptibility to SM's positive or negative effects. Looking at personality variance specifically, research has shown that those with high level neuroticism have more negative mental health correlations with SM use[37]. More broadly, Livingstone & Smith[38] added nuance to how individual factors mediate the effects of SM on YPMH, concluding that there are personal, social and digital factors at play: these personal and social factors include but are not limited to sensation seeking behaviour, low self-esteem and lack of parental support. A systematic review by Odgers & Jensen[39] corroborates these findings and states that offline problems such as family and peer problems, excessive risk-taking behaviour and psychological difficulties are perhaps some of the biggest predictors of problematic use and negative impacts of SM on YP. Finally, the Education Policy Institute's (EPI) 2021 'Young People's Wellbeing' Report suggests that the primary driver of poor mental health in YP is socioeconomic deprivation, and that SM may act as a vehicle for this[11]. This report highlights another absolutely fundamental finding present in the larger body of work that suggests that on average girls are disproportionately worse affected by (passive) SM use than boys. This conclusion is made repeatedly throughout the literature[40,41,42] and must form a guiding principle in how we perceive the role of SM in YP's lives today.

Social Media – The Role of How It is Used

In our analysis of how SM negatively impacts YPMH, we must turn to the platforms themselves. Are there predictors, implicit within the design and user interface that encourage problematic, addictive or pathological behaviours? Frison & Eggermont[41] considered whether different modes of SM use resulted in a change in wellbeing, looking specifically at 'active use' versus 'passive use'. Active use is defined as the user creating content which is then shared with peers via the SM platform in the form of posts, video sharing, private messages or likes. Conversely, passive use describes consumption of others' created content without the user contributing their own. Tying this to the discourse around gender differences, it was found that girls who use SM actively experience a positive effect on their mental wellbeing whereas both girls and boys who use SM passively report lower levels of wellbeing

and higher levels of depression. The 'active equals good' and 'passive equals bad' view has been investigated thoroughly and has been found to be a crucial factor in how SM impacts YP[43,44,45]. In considering how this idea works in practice, we cannot assume that YP fall neatly into the categories of 'active' and 'passive' users; we must consider how YP actually use SM actively versus how much they use it passively. 77% of SM users (YP and adult) actively contributed to content in 2020[2]. However, this measure is of limited use as it remains unclear how much users have to actively contribute to experience a 'net positive' effect on their mental health. Additionally, considering each person using SM spends an average of one hour and 42 minutes on SM a day[2], there is likely to be a significant amount of passive use and therefore potentially a greater negative effect on wellbeing.

How does SM design impact active and passive use? The fact that many platforms have heavily incorporated the 'infinity scroll' interface over recent years suggests a move which encourages passive SM use. Indeed, these features are the principle way users interact with content on platforms such as TikTok, which since its rapid rise in popularity in 2018 has been criticized for acting as a medium for cyberbullying[46,47], being used for a vehicle to spread hate[48] and encouraging escapism and an unhealthy avoidance of reality[49]. TikTok is also an example of a SM site that makes use of user data to algorithmically determine how to capture user attention for as long as possible, thereby encouraging passive SM use[50]. This individualisation of SM content may reinforce addictive behaviour surrounding passive SM use[51], which as we have already seen can lead to further deterioration in YPMH, thereby forming a vicious cycle. However this requires further research.

Additional Themes from the Literature

Correlation or Causation?

We have already seen how YP with specific personality traits such as high level neuroticism[37] who use SM passively are more likely to experience pathological consequences. In exploring this we must address the crucial point that it remains fundamentally unclear whether this relationship is a correlative or causative one. The effect sizes of large studies have been modest[52], leaving a gap in our understanding of how exactly SM and YPMH interact. Although the above points go some way in explaining this, Vernon et al.[53] urge caution when it comes to attributing a causative role of SM on YP mental health, claiming that some YP may be withdrawing into SM to escape their offline problems. This agrees with assertions that escapism is a main reason some YP use SM[54]. Similarly, there has been compelling research suggesting that YP with pre-existing behavioural problems feel a stronger draw to SM and interact it with it more than YP without these problems[26,55,56], again raising the 'chicken or egg' question. In considering this it is possible, if not likely that rather than increased SM consumption being the cause of worsened YPMH or vice versa, there is a bidirectional relationship at work which may see the amplification or diminution of these effects on wellbeing.

Perceived Social Support

Dunkel-Schetter & Brooks[57] were some of the first to offer mechanisms as to why, in some YP, SM has a positive impact on well-being. They offer the idea of perceived social support as a potential factor contributing to YPMH, an idea which has been foundational in more recent research[58]. Frison & Eggermont[41] advanced the idea of perceived social support to explain their findings around active versus passive SM use, putting forward the 'rich get richer' theory. This states that those with strong pre-existing offline social networks get more social benefit from using the internet, in a sense supplementing their strong offline relationships with an online support community. Of particular relevance is how this perceived social support functions in mentally unwell YP, for example those with suicidal ideation. Contrary to public opinion, Lavis & Winter[59] found that peer-based online suicide forums are highly supportive and largely do not encourage self-harm; similarly Odgers & Jensen[39] concluded that, at best, there is 'minimal and contested evidence' showing that online activities worsen YP's mental health, which includes accessing peer communities which have previously been thought to exacerbate mental distress.

Inpatient Social Media Use

An apparent gap in the literature is found when we look for a narrative on SM impact on young psychiatric inpatients. As such the following points will be made based on anecdotal accounts from psychiatric professionals contacted for the purposes of this essay, the limitations of which are acknowledged. Psychiatric inpatients are typically admitted because they are seen as a danger to themselves or a danger to others. This state of mind is usually triggered by an actual or perceived stimulus. SM allows difficult-to-manage access to content and individuals who may provide these stimuli and trigger a deterioration of a patient's mental state or exacerbate ongoing mental distress. Although some centres allow access to devices[60] some require the patient to leave their devices with nurses, family or friends and enter a 'social media deprivation' area. The ethics around this are murky: although removal of SM from young inpatients mitigates potential deterioration, there have been claims made on human rights grounds that inpatients have a right to free communication. Furthermore, access to supportive online communities could positively impact mental state and reduce patient distress, as highlighted above. On an empirical level there have been reports from psychiatric staff of patients who have obtained a device which they then use to access SM. According to one psychiatrist contacted for the purposes of this essay, the consequences of this can and have been dire. The important question of SM use amongst young inpatients will be further developed in the case presentation and discussion below.

<u>Families, Peers & Professionals: Impacts on Third Parties</u>

Families

Another important area to examine is the indirect impact, enacted through YP, on so-called third parties. We have looked at the associations between SM and YPMH, but how do these correlations impact people and environments around them to alter others' lives? It is acknowledged that this essay concerns SM impact on YPMH, but the social support mechanisms provided by family and friends are crucial in promoting and maintaining mental wellbeing. In terms of positive impacts on family dynamics, SM use has been reported to impart higher feelings of social support[61], increased levels of family cohesion[62] and generally improved intrafamilial relationships[63]. Castells[64] asserts that SM allows for 'autonomy in security situations' as it allows greater YP freedom with enhanced security measures (i.e. through live messaging and GPS tracking). However other studies have demonstrated that frequent SM use can lead to lower family cohesion[65] and increased levels of familial isolation under one roof[66]. A key explanation to this is termed the 'phubbing phenomenon', which sees the SM user ignoring physical social situations in favour of digital ones[67,68]. As well as this 'phubbing' itself being problematic, the dialogue around making arrangements to limit it by setting rules on device use in specific environments and at specific times can cause familial conflict[69,70,71].

Schools & Education

The impact of SM in social environments such as schools can to some extent be inferred from the discussion above. SM's correlation with mental ill health demonstrates an indirect mechanism through which SM impacts a schooling environment, in that if more YP with mental distress are present in any given environment, it is reasonable to assume that that environment may be less conducive to healthy social functioning and education, and may prove to be disruptive to others' mental wellbeing in turn[72]. Conduct problems and internalising/externalising behaviours also interrupt social dynamics, and cyberbullying and threats of violence made online may add to a YP's fear of interacting with peers and entering a social educational environment, potentially impacting academic performace[73]. It is worth noting that research into how SM use disrupts day-to-day education is technically challenging due to a variety of means implemented by schools and teachers into limiting SM use in the classroom.

In considering how SM use positively impacts the classroom environment, we can again assume that the discussion above to some extent applies here, i.e. a feeling of connection and community is fostered which allows for the flourishing of relationships and identity development. Another aspect

to consider around SM and education, especially in the light of the COVID-19 pandemic, is how SM can be used as a delivery method for teaching material. Dodson[74] found that most headteachers want to implement SM as an educational tool. Research has indeed shown the merits of SM when used for education[75], however the exact implementation of this requires further research before widespread uptake[76].

Mental Health Professionals

According to several psychiatric professionals contacted for this essay, SM has been used to communicate by YP on inpatient wards and post recordings of consultations and information about psychiatric staff. SM has been used as a platform for a 'game' in which patients compete by scoring as many points as possible through acts such as absconding, tying ligatures and bringing illicit substances into ward environments. Further examples of problematic SM use on wards include psychiatrist 'rankings and reviews' and arranging simultaneous disruption on the wards to cause maximal staff distress. As well as having a significant impact on staff's mental wellbeing, this negatively impacts morale and causes an erosion of trust in the patient from the doctor and a subsequent deterioration in the doctor-patient relationship, in turn contributing indirectly to worsened YPMH through suboptimal care. In searching for literature to corroborate these accounts I have found that this is an apparently under-researched field. The impact of inpatient use of SM should be subject to further investigation to assess for risks not only to the YP but to mental healthcare staff in general.

Case Outline & Discussion

Outline

The following case demonstrates some of the relevant points made in the discussion above in a real-life narrative and particularly advances the dialogue surrounding inpatient SM use. All names and identifying information in the following case have been modified to ensure anonymity and the account has been used with the patient's consent.

Background: Sarah is a 19-year-old woman who has been diagnosed with anorexia nervosa. In 2018, at the age of 15, Sarah was admitted to an inpatient psychiatric ward for the first time due to an exacerbation of her ongoing struggle with anorexia. As an inpatient she was then diagnosed with post-traumatic stress disorder.

Sarah's SM Use: Sarah had an active account on various SM platforms as an inpatient. For the ward Sarah was an inpatient on access to a device was permitted during visiting hours if a visitor attended. During her most recent admission in 2020 phone access was granted for two hours a day in light of the COVID-19 pandemic.

Sarah's Account of the Impact of SM as an Inpatient:

"In my experience the world of social media has been both a good and bad thing whilst facing mental health problems. Having access to social media whilst being in an inpatient unit for mental health was really damaging as me and my peers were exchanging our Snapchat and Instagram usernames to keep in contact in the unit, which also led to us staying in contact outside of the unit. Some of my peers got me involved in difficult situations through the use of social media, telling me their unhealthy plans whilst also putting ideas into my head. When I got discharged from inpatient everything would have went a lot more smoothly if I hadn't gotten my peer's social media accounts before coming out. Through social media I arranged to meet up with people from the hospital which got me in difficult and sometimes scary situations, and if anything it made certain aspects of my mental health worse. It's taken me over 2 years to get most people from Inpatient to stop messaging me and to leave my life, although I still occasionally get messages to this day (3 years later) from unhelpful peers I met whilst in the hospital.

I do genuinely believe there is a good side to social media whilst trying to recover from poor mental health with there being many advocates, positive messages and helpful coping mechanism ideas, but

I do believe you have to want to recover and to be in a certain place to get the full benefits of the mental health social media community."

Discussion

Sarah's case brings to life several of the themes that have been touched upon in the literature review portion of this essay. Sarah mentions, before anything else, that SM has had both a negative and positive impact on her in relation to her struggle to achieve mental wellbeing. Towards the end of the account, she mentions the positive influences, accessible through SM, that can help psychiatric inpatients, specifically positive messages and a sense of community support. This reflects the assertion that SM is both a help and a hindrance, depending on the factors highlighted above. Crucially Sarah mentions '[wanting] to recover' as a prerequisite for benefitting from online support groups on SM. This parallels with the commentary surrounding individual, offline factors as either protective or damaging when it comes to the impact of SM on YPMH. Of course, the question of what exactly makes a patient 'want' to recover is fundamental in psychiatry in general, with the interface between SM and YPMH being no exception.

It is striking that the majority of Sarah's narrative focuses on the intensely negative impact of SM on her mental wellbeing both during and after her inpatient stay. Although Sarah does not go into detail as to what exactly was being exchanged between herself and her inpatient peers, it is reasonable to assume that the risk of being exposed to distressing messages or other content was high, considering the fact that her peers were sufficiency mentally unstable to be admitted to a psychiatric ward. Sarah specifically mentions the double-edged nature of using SM to access those who are in similar situations: 'unhealthy plans' and 'putting ideas into [her] head' demonstrate the damaging impact exposure to other mentally unwell individuals through SM can have. This risky exposure continued beyond Sarah's inpatient stay and affected her for a significant period after discharge, and continues to affect her today. Sarah also mentions physically meeting people she met online and how these resulted in 'scary' situations, which relates to literature describing how SM can be used to lure vulnerable users into physical environments where they can then be made victims of violence[77].

<u>Conclusion</u>

This essay has provided a commentary on a complex topic derived from a seemingly simple question. The heterogenous manifestations of SM and how it impacts young people who are themselves unique and idiosyncratic is an extensive field of research that is still in its relative infancy. Initial research has identified that SM has both protective as well as damaging effects on YPMH. Further research has opened up this conversation to explore the 'how' and 'why' behind these initial conclusions. This has led to many theories and mechanisms being proposed, but perhaps the most important and practical predictive factors are YP's predispositions as well as how they interact with SM, which is in turn influenced by SM design. Other themes, such as causation versus correlation, impacts on third parties and psychiatric inpatient SM interaction add further depth and complexity to an already layered narrative. Finally, through Sarah's account of SM influences during her inpatient stay, we have seen how vulnerable individuals can be impacted by SM use, but also how there is a clear voice supporting it. In reflecting on the original question of whether social media is a help or a hindrance, the most fundamental common thread through all sections of this essay is the assertion that SM is both a help and a hindrance in promoting child & adolescent wellbeing. This statement must be acknowledged if we, as mental healthcare professionals, are to successfully navigate a digital landscape which is constantly shifting and growing and holds potentially life-changing consequences for YP. Perhaps, through this acknowledgement, we can start creating online and offline environments and mechanisms that place the protection of YPMH as a central tenet, and chart a new course to ensure that tomorrow's adults have the psychological wellbeing they deserve.

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Medical Student Essay Prize 2023

The 2023 iteration of the prize is now open. The topic is ***Living through lockdown - an exploration of the COVID-19 pandemic and its impact on child and adolescent mental health*.**

Prize - £500 and a free place at the annual trainee conference. For further information please see the website

Who can enter – You will be a current clinical medical student in the UK.

Deadline – 11 April 2023

Curriculum update

Dr Suyog Dhakras

At the risk of labouring an obvious cliché, issues in CAPSAC warmed up in tandem with the blazing hot July and August that we've had…(apologies could not resist 😃)

CAPSAC UPDATE:

1. **Curriculum** – I am very pleased to announce that the new CAP curriculum is now live! The training pages of the College website host all the documents including PDF versions: https://www.rcpsych.ac.uk/training/curricula-and-guidance/curricula-implementation/curricula-documents-and-resources. The documents contain the Silver Guide, the curriculum, examples of placement specific PDPs, and specialty specific end of year guidance. The implementation pages also have information regarding ongoing 'drop-in' sessions that have been planned till the end of the year. These drop-in sessions are open for trainees and trainers to use. In addition, I am happy to join TPDs and their regional STCs to discuss the curriculum and training issues if that is seen as helpful. Look out for the programme for the annual CAP Faculty Conference 2022 – Mei Simmons (CAP TPD Thames Valley Deanery) and I aim to host a workshop regarding the new curriculum – so trainees, trainers and interested colleagues are welcome. It has been my privilege to lead this work over the past 4 years and the project has been exhausting and exhilarating in equal measure. I am grateful to my CAPSAC and College colleagues for their invaluable input and help.

2. **TPDs:** I'll host an 'in-person' meeting of all the CAP TPDs across the 4 nations at the College in autumn 2022. Thank you to the Faculty Exec for agreeing to fund this meeting and Catherine Langley in helping with the arrangements and logistics.

3. **CAP Run-through training:** HEE and RCPsych have been strongly supportive in the CAP run-through training being part of the usual 'training offer' for Psychiatry recruitment. Having seen the success of the CAP run-through programme, HEE and RCPsych along with the Faculty of LD-Psychiatry started the pilot for a run-through training programme in Psychiatry

of LD in Aug 2022. My colleague Dr Mary Barrett (Chair LD-SAC) and I will hold a joint welcome event for the new trainees in both run-through streams in autumn 2022 at the College.

4. **Recruitment, Retention and Workforce issues:** Recruitment, retention and workforce issues in CAP have been at the forefront of discussions within the College, HEE and NHSEI. This has been part of the overall review of the distribution of medical training posts within all specialties across England. I have joined Elaine Lockhart and the Dean in some of these discussions. The overall recruitment for Core Psychiatry continues to be excellent (99.9%) All the posts offered for CAP & LD run-throughs were filled. For CAP the fill rate was 81.03% for Aug 2022: 58 NTNs were offered and 47 accepted. Elaine and I emphasised that recruitment needed to be to WTE (whole time equivalents) to account for LTFT trainees in FT slots. We emphasised the need to continue supporting our trainees to find the most appropriate work-life balance for themselves (so decide how they would train in terms of FT or LTFT) – as that would significantly affect their wellbeing and help promote resilience and longevity in their careers. There is the prospect of a further dedicated increase in funded CAP NTN numbers for Aug 2023.

5. **Call to trainers:** Elaine and I want to emphasise how important it is for consultant and SAS colleagues to participate in training and supervision of our trainees – and to also take on formal supervisory roles. We plan to meet the network of national DMEs (and CMOs too if need be) coordinated by the College and by the Dean Subodh Davé to emphasise the need for employer trusts to ensure that substantive child and adolescent psychiatrists are empowered and enabled to have time in job-plans to train and enthuse our trainees and also participate in undergraduate medical student teaching to increase the exposure to CAP. There is an expansion in FY posts and hosting FY trainees in CAP would be another way to increase the exposure to CAP and hopefully impact on recruitment. I think medical students and junior trainees will be inspired by the dedication, enthusiasm, and commitment of all of you.

CAPSS Summer Newsletter

CAPSS Executive committee

Study Updates

We currently have two studies that we are collecting data on, *Far Away From Home* and *ARFID.* Both began Spring 2021.

CAPSS ARFID Surveillance Study Update

The initial surveillance on ARFID is now closed but we are still collecting the questionnaires. During the 13-months surveillance period, child and adolescent psychiatrists have reported a total of 294 cases, 96 of which have been confirmed cases. We are yet to receive the completed questionnaires for 74 cases.

Please can we request those of you who have reported cases to return the completed questionnaires, or alternatively a member of the study team can complete these with you via video conference/telephone at a convenient time.

By completing the questionnaire, you will be directly contributing to the evidence base that will:

- Help inform and influence care and treatment in the future
- Better match patient needs with commissioning priorities and funding allocations
- Generate new priority research questions

This study is being led by Dasha Nicholls, Javier Sanchez-Cerezo, Josephine Neale, Lee Hudson, and Richard Lynn. More information at https://www.rcpsych.ac.uk/improving-care/ccqi/research-and-evaluation/current-research/capss/capss-studies

The baseline results are due to be presented at the child & adolescent Faculty meeting this autumn.

Far Away from Home Study Update

The "Far Away from Home" study has received notifications on 249 cases that were directly reported via CAPSS e-cards, during the surveillance period (Feb 21 – Feb 22). If your reported case met the study eligibility criteria, you may have already heard from us or may hear from us very soon with a request to complete a brief follow-up questionnaire. We are extremely grateful for your ongoing support of this important study by continuing to complete these 6-month post-admission follow-up questionnaires. The information that you provide during this follow-up stage is crucial in helping us to better understand the clinical and service use outcomes associated with the different types of admissions we are looking at (far from home, out of area, or to an adult ward), and to improve the evidence base for future service commissioning.
Our follow-up questionnaire is much shorter; it should only take five minutes to complete using our secure online questionnaire. We are also very happy to support you with its completion if you would prefer to complete the follow-up questionnaire over the telephone with a study researcher or via a fillable pdf.

If you haven't yet completed your questionnaire or if you receive one in the coming months, we would be very grateful if you could complete it so that we can achieve an 85-90% response rate and ensure that the study findings are as valid and representative as they can be. As a token of our appreciation and in recognition of the time that you have spent completing our baseline and follow-up questionnaires, we are able to offer a CPD Certificate of Research Participation which you could use as part of your appraisal portfolio.

Our "*Far Away from Home*" Summer Newsletter is available to view online at https://mailchi.mp/5192c7cccb2b/far-away-from-home-summer-newsletter. Please email us at faraway@nottingham.ac.uk if you would like to receive future study newsletters which provide regular study updates.
Professor Kapil Sayal, Dr Josephine Holland & Dr James Roe

New Studies being considered
Surveillance of Neuroleptic Malignant Syndrome (NMS) following treatment with antipsychotic medications in children aged 0-16 years presenting to secondary care in the UK and Republic of Ireland (ROI)

Neuroleptic Malignant Syndrome (NMS) is a rare but serious complication of antipsychotic medications. It affects all age-groups and can occur at any point in the course of treatment with an antipsychotic medication. Many children and young people (CYP) are prescribed antipsychotic medications for a variety of indications including, psychosis, bipolar illness, and adjunctively for management of challenging behaviour in ASD. There is no prospective data in the UK or elsewhere on how often NMS occurs among CYP prescribed antipsychotic medications. The limited data makes

it challenging for doctors to explain the risk of NMS to CYP and their parents when considering antipsychotic medications. Thus, we propose a prospective surveillance study to provide a more accurate estimate of the occurrence of NMS among CYP treated with antipsychotic medications in the UK and ROI. We plan to carry out a 2-year joint case ascertainment through the Child Adolescent Psychiatry Surveillance System (CAPSS), and the British Paediatric Surveillance Unit (BPSU). The study is at an advanced stage of development. We will share more information before the study starts.

Webinars and Masterclasses

CAPSS are continuing with their programme of training events and webinars this year. After their first successful masterclass, booking is now open for the next in this series of focused training days. The next masterclass will be with Dr Bruce Clarke and Dr Lauren Peile, on assessment and treatment of young people with OCD. Further information on all these sessions with links for booking are provided on the **CAPSS events page**.

Masterclasses:

- **CAPSS Masterclass #2: Assessment and treatment of young people with Obsessive Compulsive Disorder: Exploring pharmacological and psychological best practice**
- Speakers: Dr Bruce Clark with Dr Lauren Peile
- Date: **7 November 2022**
- Location: RCPsych, London
- Times: 9.00am to 5.00pm (TBC)
- ***Booking now***

- **CAPSS Masterclass #3: Difficult to treat depression: assessment factors**
- Speaker: Dr Aditya Sharma
- Date: **21 November**
- Location: RCPsych, London
- Times: 9.00am to 5.00pm (TBC)
- ***Further details to follow. Booking opens soon.***

Webinars:

- **Foetal Alcohol Syndrome**
- Speaker: Dr Raja Mukherjee
- Date: **25 November**
- Zoom webinar, 2.00-3.00pm (TBC)
- ***Further details to follow. Booking opens soon.***

On-demand webinars:

- Recordings of past webinars are now available to purchase from the CAPSS website. On receipt of payment for your chosen webinar, the CAPSS team will provide a link to an online recording of the session.
- CAPSS webinars are available to all.

Publications

Key socio-demographic characteristics of children and adolescents with gender dysphoria: A British Isles surveillance study" published through
SAGE Publishing and *Clinical Child Psychology and Psychiatry* June 2022
https://doi.org/10.1177/13591045221108840

CAPSS Reporting
Not yet a member of CAPSS or a new consultant? **Join CAPSS here**
See our website for more information on **CAPSS studies**

Remember:
These are active surveillance studies, so responding "**Nothing to report**" is just as important as responding with a positive case
Participants will be eligible for **CPD certificates** for appraisal purposes

Not receiving your e-Cards? Please add us to your Safe Sender list. Don't forget to check your junk email and keep your contact details up-to-date with the CAPSS team: capss@rcpsych.ac.uk

Follow-up questionnaires will be sent by the study teams. When reporting a case, it may help to keep a note of the relevant patient to help with identification later. The study teams are more than willing to assist in the completion of follow-up questionnaires.

c/o Catherine.Langley@rcpsych.ac.uk

ecoCAMHS workstream and Sustainability Champions

EcoCAMHS update – Don't be a bystander

Our work continues to explore the interface between nature, climate and child mental health. These are turbulent times and the heatwave and drought are the latest reminders for us about the state of the environment on which we all depend. Worryingly, there has been a clamp down on peaceful protest and medical professionals who take part in non-violent climate protest are being arrested.

This is a very stressful time for young people to be growing up in and they need us to be the 'adults in the room' about this issue. Our work is so busy that it can be hard to look beyond the stress, risk and anxiety, especially to face something as big as the climate crisis. But it often feels better to face it, understand what role we can play, and to get involved – alongside other people.

There are many ways to do so and in the Autumn, we are launching our 'EcoCAMHS Top Tips to benefit Climate Nature and Wellbeing' to explore this further. We will be running a workshop on Day 2 of the Annual Conference – please come and join us to discuss.

For anyone interested in how to make their practice more nature friendly – please check out this "Nature-based training for Psychiatrists" in Sussex. Maybe see you there?

Read about our work to date in our article "If not us, then who?" or email us to find out more about our current projects.

We would like to say thank you to our colleagues in EcoCAMHS for their support and work and say welcome to this year's CAMHS Green Scholar, Alexia Haysom.

Nicholas.barnes@nhs.scot catriona.mellor@oxfordhealth.nhs.uk

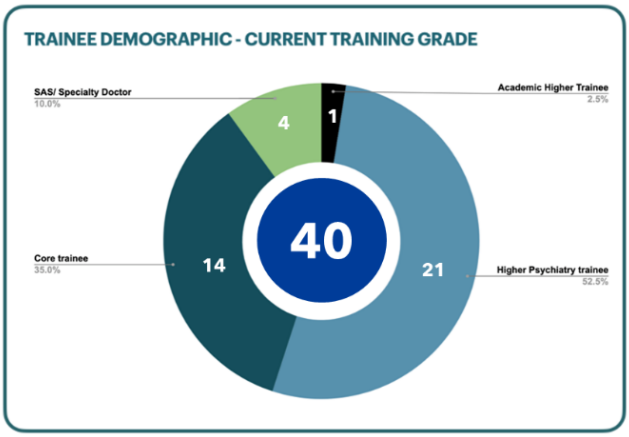
Paediatric Liaison Network

Dr Ashy Rengit
Paediatric Liaison Network

With thanks to the PLN Executive Committee
Dr Virginia Davies, Dr Sophia Williams, Dr Ashley Liew, Dr Ruth Garcia-Rodriguez and Dr Isabel Paz

& The Royal College of Psychiatrists (RCPsych)
Dr Elaine Lockhart, Dr Annabel Price, Stephanie Whitehead, Catherine Langley and Thomas Denning

Introduction



Objective

This project aimed to gather information from psychiatric trainees across England, Wales, Scotland and Northern Ireland, regarding their experiences and views of training in paediatric liaison psychiatry.

The PLN Trainee Survey

The survey was open between 29th November 2021 to 17th January 2022 - with trainees from the RCPsych Liaison Psychiatry and Child & Adolescent Psychiatry faculties invited to participate.

Overall, 40 trainees across the UK completed the survey detailing their views and experiences of paediatric liaison psychiatry training.

Key themes

Awareness

Most respondents (85%) were aware of paediatric liaison psychiatry as a specialty, regardless of whether they had been able to access experience in this field. A minority of those surveyed were aware of previous collaborative initiatives between paediatricians and psychiatrists working in young people's mental health (9 out of 40 respondents)

Availability

The availability of training appeared to be highly dependent on the quality of investment into local paediatric liaison services, with most formal training posts and departments (including child & adolescent psychiatry input) being based in London. Less than half of the respondents (47.5%) were in training programs which included paediatric liaison psychiatry experience.

Trainees also highlighted particular difficulties with working in paediatric settings due to organisational differences (i.e. in terms of local Trusts or training providers) and/or disorganised clinical service structures. This raises concerns regarding disparity in:

a. Training - for psychiatrists with limited opportunities in their localities due to the lack of adequately resourced paediatric liaison services. This is also especially difficult for trainees with other personal commitments e.g. childcare, who find it difficult to travel out of area to access desired training opportunities available elsewhere.

b. Quality of care - for young people, who would benefit from a system of care that gives equal priority to their physical and mental health.

Accessibility

In addition to wider services, trainees also identified other factors influencing the quality of paediatric liaison training accessible to them:

a. Appropriate supervision - the lack of paediatric liaison psychiatrists available to oversee training was highlighted as a key issue by respondents (this also includes areas where paediatric liaison care was delivered by community teams, or other multidisciplinary professionals) In particular, trainees responses noted that it was difficult to identify appropriately qualified supervisors, as there was little support available for them to do so.

b. Trainee-centred approach - trainees identified a mismatch between their goals of sub-specialising in paediatric liaison psychiatry, and the support available from trainers to facilitate this process.

Anecdotes from trainees summarised negative experiences with consultants, limited scope for modifying their job plan to meet training needs, and lack of advertised paediatric liaison opportunities as key factors influencing their experiences.

Recommendations

Paediatric liaison services

The responses in this survey capture the importance for trainees of increasing the provision, and quality, of paediatric liaison services across the UK. In the absence of such initiatives at present, the following recommendations are based on trainee feedback about priorities for paediatric liaison training going forward.

Training opportunities

Survey feedback emphasised the need for increased subspecialty tasters, offered within training programmes, for promoting exposure to paediatric liaison psychiatry. The idea of gaining further accreditation as a higher trainee (ST4 - ST6) in paediatric liaison psychiatry (similar to general adult psychiatry training) was also viewed positively by respondents completing the survey.

Sub-specialty engagement

Respondents highlighted areas for meeting their training needs within paediatric liaison psychiatry - in particular, more opportunities for shared experiential learning with paediatricians in sub-specialty settings according to special interest. The need for a wider network to advertise formal

clinical/ research training opportunities and specialist learning initiatives, such as case discussions, was also conveyed by trainees during this survey.

To view the full report - please visit this link

https://drive.google.com/file/d/1F7QZp9VX3Ah6VrcOUPlKSsSklFfsDGbT/view?usp=sharing

CAP Summer Newsletter PLN Update

Dear readers

We have had a period of change within the Paediatric Liaison Network. We are delighted that Elaine who was chair of the PLN and a liaison psychiatrist is now the chair of the child and adolescent Faculty. Elaine has always been an inspiration to us all and is good that the profile of liaison is increasing within the college.

Unfortunately, Ginny has stepped down as chair of the PLN, and is now enjoying a well-deserved and very active retirement. We hope that she will continue to give us her wisdom for years to come, in the same way that Elena Garralda and Sebastian Kraemer have done. Their contribution and support of the specialty are invaluable.

We, Ruth Garcia and Isabel Paz, were appointed as new co-chairs of the PLN, and although the gap left from our illustrious predecessors feels like impossible to fill, we hope that with their guidance we will succeed at continuing to advocate for improving the mental health of children presenting to paediatric and acute hospitals. We are yet to appoint a vice chair or a secretary, but we are surrounded by a fantastic group of enthusiastic colleagues who will continue to help us on the way.

Now with a summary of our activity in the last few months:

NHSE task and finish group

Birgit and Prathiba have been working together in this group, which has now come to an end, with some follow up meetings coming up to evaluate the work.

There is a new group forming, the New NHSE CYP Crisis Services Task and Finish Group, to look specifically at self-harm presentations and the role of CAMHS crisis teams. This is completely independent from the previous task and finish group. The PLN is keen to be involved and contribute and will report back accordingly.

Links within RCPsych

PLAN

Birgit and Ginny have represented the PLN in the Psychiatric Liaison Accreditation Network to represent children, and to add paediatric standards. These standards are under constant review and the 6th edition is about to be published. In the new edition the number of standards has been reduced and now include children and young people (thanks to Ginny and Birgit). Special attention has been given to sustainability, as well as equality and diversity and for members of the LGBTQ+ community.

Sadly, Birgit is stepping down from the Accreditation Group and Ginny from the Advisory Group. We would like to encourage interested members to get involved and approach PLAN directly (cassie.baugh@rcpsych.ac.uk) about joining one of these two groups as the under 18s reps.

For more information on PLAN, visit the website

Liaison Faculty

Birgit continues to be an elected member of the committee, and Isabel and Ruth will replace Ginny as co-opted members. The next meeting is taking place on the 15th of July. The number of children presenting to acute hospitals with a mental health crisis is continuing to increase. Often the acute hospital becomes a place of safety for children in crisis in the absence of Tier 4 CAMHS beds or other alternative provisions, and therefore is important that the PLN represent the needs of these children and their families.

Links with the RCPCH:

PMHA

The Paediatric Mental Health Association is an organisation of enthusiastic paediatricians who have a strong interest in mental health. They have a website with resources and organise an annual conference and webinars.

There is an RCPCH conference in July and as part of this PMHA will hold their meeting as one of the SIGS. Rory Conn and Birgit Westphal have been active members supporters of this group. Birgit is now stepping down, and Isabel and Ruth are already linking up with the group to continue to strengthen relationships. Given the increasingly overlap between paediatrics and CAMHS, we hope that the RCPCH will encourage their members to join the PMHA.

SPIN training

There is a new specialist interest module on mental health in paediatrics developed by the RCPCH with Suyog Dhakras' input and available on the RCPCH website, which is proving very popular. This is different to the GRID posts.

PLN Research group

Ashley Liew is our research lead and we are privileged to have Elena Garralda supporting us with her wisdom in this area. Ashley is continuing to be involved in the creation and development of a standardised delirium measure for UK.

Rory Conn has taken a new role working for Duchenne UK to establish research questions and develop pathways of care as these patients have high psychiatric morbidity. Dr Vineland is already working with adults with Duchenne.

ASLG

Ginny Davies has continued to work on designing child mental health modules for the ASLG acute mental health (APEx) course, which was adult focussed. Karen Street will be advising on how this training might link with RCPCH's drive to skill up the paediatric workforce.

Trainees' feedback

Ashy Rengit completed a national survey of trainees looking at knowledge and experience of paediatric liaison psychiatry. You can read the full report in a later section of this newsletter.

Unsurprisingly it shows a lot of variation around the country, with many trainees not having access to any experience at all outside of London and other major centres.

Sadly, as both have been in post for 18 months a new set of trainee reps will be needed to join us. **We will be seeking Expressions of interest from trainees wishing to become the next CT or ST reps starting in January 2023.**

PLN Summer Meeting and Future meetings

The PLN Summer Meeting was hosted by Isabel in Oxford, although held remotely, and consisted of two extremely good talks by Sharon Taylor and Terry Segal on long covid, and Harriet Stewart on Tics. Both talks included patient experience, which made them even more relevant. We had very good feedback on both presentations.

Our next meeting will be in January 2023, and we hope to be able to hold it in a hybrid model (both face-to-face and online), as we have had an increase in interest from colleagues abroad and would like to maintain those links as much as possible.

We want to finish this section with an enormous thank you to all our members who are very generous in sharing their expertise with others, and are an incredibly enthusiastic and knowledgeable bunch, always representing the needs of children with mental health issues in paediatric settings with relentless energy.

Have a good summer, and please join us in any of our meetings if you would like to know some more.

BW

Ruth Garcia and Isabel Paz

Report on the 2022 RCPSYCH Wales National Mental Health Debate for Primary Schools: Does technology improve your mental health?

Dr Joanne Wallace, CAP Faculty Run through Rep

It was a pleasure to attend the online RCPsych Wales National Mental Health Debate for Primary Schools organised by Oliver John and Antonia Fabian, RCPsych Wales and TEC Cymru. Submissions were invited from primary schools across Wales, for and against the motion: Does technology improve your mental health?

The event started with some poignant thoughts from the Welsh Children's Poet Laureate Connor Allen and from Lleucu Siencyn, Chief Executive of Literature Wales focusing on how literature and debate can be used to promote health and wellbeing and encourage curiosity in young people.

Before we heard the motions a poll of attendees showed that 61% felt that technology does improve your mental health, so how did the motions put forward by children from across the Wales influence this?

Entries were passionately delivered with pupils quoting stats and figures from recent research to support their motions. Pupils for the motion argued that the benefits of technology far outweigh

the risks. Pupils spoke about how invaluable technology has been during the pandemic, making it possible for education to continue and for people to stay in touch and socialise online. Pupils told us about using apps for education, to promote health and wellbeing and increase your fitness levels. Pupils felt that technology gave us so many ways to relax and connect with others, they mentioned video streaming and gaming in particular as great ways to enjoy yourself online. Pupils supporting the motion posed the question to the audience: Can you really imagine a world without technology?

Pupils submitting entries against the motion spoke about the damaging effects technology can have on our mental and physical health and our relationships. Pupils quoted studies linking screen time to depression, headaches, and poor sleep. Pupils spoke about the dangers of cyberbullying, catfishing, and the effects of seeing lots of negative online content on your mental health and self-image. Pupils questioned if technology was violating young people's right to privacy and the effect this had on young people not been able to "disconnect". One pupil told us incredulously that you don't need a fitness app to enjoy a walk outside and other pupils also felt that technology meant that children missed out on real world experiences.

After the motions for and against we heard from Lleucu Siencyn, Chief Executive of Literature Wales and Journalist Melanie Owen, they spoke about the need to help young people stay safe while using technology but also to encourage young people to reap the benefits. Mike Tate, Director of Education, Cardiff Council closed the debate commenting that supporting young people to develop the ability to listen and reason was so important as it equipped young people with the power to make up their own mind-an invaluable skill online and off! All the pupils who took part were highly commended, best speakers were picked and winning schools announced, looking at Twitter after there were some very proud pupils and educators celebrating taking part in the debate.

After the debate 76% of attendees felt that technology does improve your mental health, having heard the arguments both for and against I'm not sure there is a clear victor, but certainly the pupils are right when they say technology is here to stay and we need to focus on equipping our young people to navigate this ever-changing environment safely to protect their current and future wellbeing. I look forward to next year's debate…

PSS Update

Dr Declan Hyland
Dr Ros Ramsay

What is the Psychiatrists' Support Service (PSS)?

The RCPsych's PSS was set up over 10 years ago to provide free, rapid and high-quality peer support by telephone to psychiatrists of all grades (Core Trainees, Higher Trainees, Specialty Doctors and Consultants) who may be experiencing work-related or personal difficulties or issues. This may include issues with training, MRCPsych exams, work-related stress, bullying or undermining and physical health and/or mental health issues.

The PSS is totally confidential and delivered by Peer Support Psychiatrists (PSPs), some of whom are Higher Trainees and some of whom are Consultant Psychiatrists. The service is available to psychiatrists in locum posts as well as substantive posts and to psychiatrists working in any area of England, Scotland, Wales and Northern Ireland.

The PSS can signpost those psychiatrists that use its service to a number of organisations that may be able to offer further support and guidance, including British Medical Association (BMA) support services, Doctors in Distress, Doctors' Support Network, NHS Practitioner Health, DocHealth and the Sick Doctors' Trust, as well as advising on when may be appropriate to consult the General Medical Council and a psychiatrist's medical defence union.

Why did I become a Peer Support Psychiatrist (PSP)?

As a Consultant Psychiatrist myself, I knew little about the PSS until I joined the service as a PSS. In fact, I am doubtful I had even heard of its existence! In my previous role as Chair of the RCPsych North-West Division, I was keen to learn more about the service and how it may benefit members in the Division. Thus, when the opportunity arose for the PSS Chair, Dr Ros Ramsay, to speak at a North-West Division Executive Committee meeting, I was keen to oblige. Me listening to Ros' presentation about the PSS sparked an interest in my wanting to join the service as a PSP. I felt this was an opportunity for me to give something back to the College and, at the same time, to aid my self-development as a listener, communicator and facilitator.

How do I become a PSP?

The process of recruitment involves a formal expression of interest and an interview to determine suitability. Higher Trainees, SAS doctors and Consultant Psychiatrists are all eligible to apply to be a PSP. If appointed to the role, it is voluntary and offers the flexibility of offering as much or as little time as you are able to afford and with no minimum time commitment. Calls to those psychiatrists that access the service can be done outside regular working hours.

Support for PSPs

As a group, PSPs meet on a regular basis for reflection and facilitated peer supervision and to engage in relevant CPD. The group of PSPs is heterogenous, with psychiatrists of differing levels of experience in the role, including several that have been PSPs since the service was set up.

How do I contact the PSP?

The PSS is available during office hours from Monday to Friday, with a dedicated telephone helpline - 020 8618 4020. Alternatively, psychiatrists can contact the service confidentially via email - pss@rcpsych.ac.uk. You can also find information about the PSS on the PSS page of the RCPsych website (Psychiatrists' Support Service (PSS) | Royal College of Psychiatrists (rcpsych.ac.uk)). You can also follow the PSS on Twitter @rcpsychPSS.

My final thoughts….

I have really enjoyed my time as a PSP. I have always felt supported in the role and feel that the role constantly challenges me. The PSS is keen to recruit more PSPs - why not join?!

Use of Clozapine in under 18's for Treatment Resistance Schizophrenia: A Literature Review

Dr Omar A Choudhry

Abstract

Clozapine is frequently used as the last line of treatment for cases with treatment resistant schizophrenia (TRS), even in the paediatric population. This literature review highlights the utility and challenges of using clozapine in under 18-year-olds with TRS.

Literature Review

The literature around the utilisation of clozapine in children and teenagers is constrained, as the majority of the studies looking at its use are within the over 18 (adult population) with TRS. Clozapine is considered to be the foremost feasible antipsychotic for the treatment of TRS. Given its low chance for developing extrapyramidal side effects and predominant efficacy and tolerability compared to first-generation antipsychotics (FGAs) and second-generation antipsychotics (SGAs), it was pulled back from use in 1975 when 17 out of 2660 (0.7%) patients treated with clozapine in Finland developed agranulocytosis of which 8 patients sadly died [1]. It was not until 1988, when Kane et al, affirmed clozapine's safety and superiority in TRS, that it was at long last affirmed for the use of TRS with standard haematological monitoring [2].

Mild psychotic symptoms in children and adolescents are fairly common, but the prevalence for more severe forms of psychosis, that match the criteria for schizophrenia are far less common [3]. Lifetime prevalence rates are roughly 0.5% and early childhood onset rates are approximately 0.04% [4]. Clozapine has demonstrated effectiveness in TRS in adults for a long time and now an emerging body of evidence supports the safe use of clozapine in children [5]. Case reports for the successful use of clozapine for TRS in children were first published back in 1992 [6].

The National Institute for Health Care Excellence on Psychosis/Schizophrenia in children and young people highly recommends that clozapine treatment should be offered to children with schizophrenia who have not responded well to pharmacological treatment, (i.e., failure of adequate doses of at least 2 different antipsychotic medications sequentially administered for 6 to 8 weeks each). Similarly, The American Psychiatric Association recommends that patients with TRS should be treated with clozapine, especially if the risk of suicide remains substantial. Despite these guidelines and emerging evidence supporting the use of clozapine in children with TRS, clozapine remains significantly underutilised [7].

The main barrier to the use of clozapine is primarily how adverse reactions are related to the drug, which are of significant concern for users, families, and clinicians, especially when dose-related adverse reactions like leukopenia and neutropenia are more readily reported in children than in adults [8]. Nevertheless, it is still exceptionally rare for children to develop agranulocytosis, and the incidence appears similar between adults and children [9]. In addition, children very rarely develop myocarditis in response to clozapine treatment [10]. Contrary to this, it is well-established that clozapine is associated with a dose-related increased risk of metabolic syndrome and a lowering of seizure threshold [11]. Although the population of children requiring clozapine is much smaller in number, the resource allocation to support these complex children is significant. Given the challenge of long-term

poor prognosis for children with early-onset schizophrenia, it is imperative that we strive to enhance outcomes in this patient group [12].

In a recent systematic quantitative meta-review, clozapine appeared to show significantly superior effects on positive, negative and overall symptoms and relapse rates in TRS and non-TRS compared to FGAs and SGAs in TRS. In addition, despite the high risk of metabolic and haematological adverse-event profile compared to other antipsychotics, hospitalisation and mortality rates of clozapine showed a pattern of superior overall efficacy compared to FGAs and SGAs in schizophrenia [13].

In another retrospective review of clozapine use in children and adolescents, of the 28 inpatients receiving clozapine during the study period, 82% were taking clozapine at discharge and of these 96% experienced improvements in the Brief Psychiatric Rating Scale and Children's Global Assessment Scale scores. The mean length of hospital stay following clozapine initiation was only 60.7 days. Although, there were higher rates of benign haematological adverse events, but no episodes of severe neutropenia. In addition, the majority of patients were of ethnicity associated with higher risks for metabolic adverse events [14].

In a recent study looking at the off-label clozapine use in young people, the study highlighted that there was little consistency in prescribing clozapine, such as how long it should be administered and the length of follow-up patients require. In spite of this, clozapine continues to be used for the benefit of young patients. Therefore, indications for the prescription of clozapine should be revisited as majority of the available studies are small in number. Hence, larger studies should be conducted to provide more statistical power and determine clear guidelines for use, along with the risk of side effects and long-term adverse events that may arise [15].

Another interesting study found that, 95% of paediatric patients admitted with or started on clozapine during an acute psychiatric hospitalisation were discharged on the medication. The high incidence of adverse events should reinforce to clinicians the need for vigilant monitoring. Paediatric guidelines recommend clozapine for TRS but stress the critical need to ensure an accurate diagnosis. Unfortunately, limited data exists for the use of clozapine in paediatric patients with other diagnoses [16].

Conclusion

TRS is very often a terrifying and debilitating condition, not just for the individual but, also for the family and carers. Reports have suggested that the outcome is not generally favourable, as the condition itself is a progressively deteriorating disorder. However, failure to treat children who do not respond to routine treatment because of a fear of side-effects is unacceptable, as the risk of not treating schizophrenia is far more serious than the adverse effects of treatment. Furthermore, a delay in treatment is often associated with poorer and more chronic outcomes, as the longer the duration of untreated psychosis, the worse the condition becomes, with functional outcomes declining rapidly. The persistent positive, as well as negative symptoms, are highly destructive to a child's development, massively hindering progress at school, their family and peer relationships [17].

The suicide rate in patients with TRS has also been noted to be much higher than in non-TRSs. Early treatment with clozapine has shown the potential to reduce the secondary impacts of this serious mental illness. It has even been suggested that clozapine should be positioned as a second-line treatment for first-episode schizophrenics who fail one trial of a second-generation antipsychotic [18].

In recent times the scientific literature regarding clozapine is vastly increasing and evidence-based psychiatry might help clinicians to judge the best evidence and decision-makers and clinicians are overstrained by the number of individual studies, reviews and meta-analyses.

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The Squeaky Wheel

Dr Rory Conn

"Sometimes the healthiest wheel is the squeaky wheel: why children and young people come to the attention of health services, and the meanings made of this"

Psychiatrists and psychologists recognise that a child's behaviour, when unusual, troubling or troublesome, is often a reflection of a disturbance in the system around them. This is an unconscious process. The function of that behaviour can be to draw the attention of professionals to that which is (or should be) concerning: abuse or neglect, parental mental illness, bullying and so on.

Such behaviours, especially when involving repeated attendance in crisis, for example sequential overdoses or self-harm, are commonly mislabelled as "attention seeking". This has pejorative connotations and is both dismissive and unhelpful. I prefer "care seeking" when the child is appealing for emotional support or containment and "change seeking" where the necessity is for something to alter, a practical difference to make the life of the young person and their family safer, and more tolerable.

Rather than representing illness, these behaviours are often understandable responses to distressing life events, or future uncertainties. Medicalising them through diagnosis-seeking can be dangerous.

Analogously, children are commonly referred to paediatric departments with physical symptoms which cannot be explained medically. That is to say, organic pathology has been ruled out; there is no biological illness to explain the symptoms described. And yet the symptoms are experienced just as keenly as those with a physical causation: chronic tummy pains or headaches, debilitating fatigue, loss of vision, sensation or motor control. In comparison to the child harming themselves or causing disruption, these are known as 'internalising' as opposed to 'externalising' symptoms. Again, medicalisation must be avoided.

Fundamentally, a child may lack the emotional maturity and linguistic sophistication to give words to their predicament. In such situations it is their actions or their body that 'does the talking' on their behalf. There is clearly a problem to be addressed, but a belief that the answer lies in diagnoses, medical investigations and interventions is fallacious.

Take, for example, the 11-year-old girl who has developed unexplained weakness in her legs, and 'drop attacks' (episodes in which she suddenly falls to the floor, apparently unconscious). These appear only to happen at school. An admission to the paediatric ward involves a wide range of investigations, scans, and tests, which are expensive and invasive. Epilepsy and other brain disorders are ruled out. On the 5th day, our patient is introduced to a child psychiatrist. He spends time with the girl, with her mother, and later with them both, together. He learns that the symptoms began shortly after the death of her maternal grandmother, who had been ill for some years with dementia, and was living in the family home. Her father left some years ago, following domestic violence, which she witnessed. He was never prosecuted. Since grandmother's death, Mum has been tearful and withdrawn, lacking in purpose now her caring responsibilities have come to an end. Mum admits to feeling suicidal, and her daughter nods silently, apparently unable to speak.

It is not the girl who is traumatised or unwell, but the mother, who is bereaved.

An intervention is made by the psychiatrist to link Mum with an adult mental health team. She also meets with a social worker who gives advice about the financial difficulties the family are in. In a few short weeks, our patient is back in school, walking normally and feeling relieved to have 'recovered'.

How do we understand what occurred? The child psychiatrist's job here, in conjunction with the paediatric team, was to understand the drivers of these very real physical experiences. He applied the so-called 'Bio-Psycho-Social Model' to see the young person in the context of their environment.

Such cases are universal in healthcare, but often overlooked. When a family experiences a major change, it is not uncommon for the youngest members to be the 'vehicle' of expression – the so called "Identified Patient". Families are finely balanced systems. If one mechanical aspect is failing, other elements may take on additional strain and burden, practical or psychological.

The psychiatrist here is like a mechanic, and the 'squeaky wheel' is the problem which is brought to his/her attention. Importantly and commonly, the vehicle itself may not need new parts fitting, but it does need realignment. In our particular case, the girl was suddenly the bearer of additional 'weight' (the responsibility for worrying about her mother's state of mind). In truth, her symptoms helped save her mother – it could be seen as rather heroic, had it been intentional.

Western health systems must evolve to become more sophisticated in their understanding of the interplay of the physical, the psychological and the social. This involves challenging received wisdom, better educating future generations of clinicians, but also altering societal discourse about what illness truly is.

Using 'experts by experience' to improve and develop the mental health services offered in the NHS

Emma Wakefield

Abstract

Within the National Health Service (NHS), a shared constant aim of services is to provide the best outcomes for service users as possible, which can be done through continuous service development. Due to this, service improvement should be at the forefront in mental health provision and co-producing with those who have experience of that service helps professionals make care more person-centred, therefore providing better outcomes. This dissertation investigates the relationship

between using experts by experience and professionals, and how they can co-produce together in order to continuously improve mental health services. Relevant literature and primary research were analysed in this dissertation, highlighting the perceived value of using co-production and experts by experience in service development. Feedback from an online questionnaire had 42 responses, who all had experience and working knowledge of this approach, as they were staff members or experts by experience. The analysis conducted of the primary and secondary research showed the importance of co-producing when improving mental health services, however, it also discussed the potential barriers and limitations. Overall, it can be concluded that it is beneficial for services to use experts by experience when improving their services, and that not utilising co-production can make it difficult to meet service users' needs. Using the results of this study, the researcher hopes it inspires and encourages other areas of the NHS to improve their services this way, using this dissertation as evidence.

Please follow the link to take a look at the whole dissertation.

Delivering a Summer School using a blended approach

Saiba A, Young Person Advisory Panel, Technology Enabled Care (TEC) Cymru

In July of 2022, TECCymru in collaboration with the Royal College of Psychiatrists, Wales held their first summer school for young people in Wales between the ages of 16 to 18 with an interest in the healthcare field and mental health in particular. The summer school took place over two days and aimed to give the young people involved an insight into various career paths relating to health care, as well as opportunities to understand the various aspects of the field by engaging in activities and talks with professionals.

The first day of the summer school took place at the RCPsych Cardiff Office with the day beginning with introductory talks from Professor Alka Ahuja, Gemma Johns, National Research lead TEC Cymru and Ollie John, RCPsych Wales who gave the children some information about the work of both TECCymru and the Royal College.

The day then proceeded with talks from professionals both online and in person. The students were given the opportunity to discuss how to study a medical career during a talk with Megan Barker, a medical student, who talked the young people through the steps for pursuing a career in medicine.

Following this, the young people got to explore the differences between careers in psychology and psychiatry whilst talking to Anne Marie McKigney, a child psychologist and Joanne Doherty, a specialist Child Psychiatry trainee and Elaine Lockhart, Chair CAP Faculty who spoke about how they help those with mental health problems. The young people also got to develop their understanding of how methods to combat mental health issues are being learnt about and improved in a talk with the Research Lead of TEC Cymru, Gemma Johns.

Later on in the day, the students took part in various interactive workshop. These included a workshop led by Ollie which considered what steps should be taken to support the mental health and wellbeing of refugees coming to the UK, and also a workshop led by Kathryn Speedy, specialist Child Psychiatry trainee exploring the effect of environmental changes on mental health.

The young people really enjoyed the wide variety of events held on this day with one remarking how 'it was so interesting to meet such a wide variety of people and learn about mental health from

many perspectives.' They were also able to reflect on their informative discussions on mental health on the second day of the summer school where they visited the Welsh Senedd to explore how public services and policy- making interact with health services to support mental health.

Overall, the summer school was a really enjoyable experience for all involved and using a blended approach of delivery opened this to a lot of young people (including one young person who was isolating at home). TECCymru and RCPsych hope to continue the programme over the coming years and expand the age range of young people involved to continue providing an insight into mental health and the healthcare field.

Contacts and leads within the executive

Please get in contact with area leads if you would like to become more involved with College work

Contact the Faculty Exec and any of the contributors c/o
Catherine Langley, Faculty & Committee Manager: catherine.langley@rcpsych.ac.uk

Dr Omolade Abuah	Elected Member
Dr Hetal Acharya	Trainee Representative
Prof Alka Ahuja	Vice-Chair
Dr Nisha Balan	Trent, Patient Safety Group
Dr Nicholas Barnes	Specialty Doctor representative and Sustainability Champion
Dr Anupam Bhardwaj	Regional Representative for the Eastern Region
Dr Phillipa Buckley	Elected member
Dr Prathiba Chitsabesan	NHS England link
Dr Rory Conn	Elected member, RCP link
Dr Anna Conway Morris	Co-opted member
Dr Andrea Danese	Academic Secretary
Dr Ananta Dave	Safeguarding lead, Policy Lead
Dr Suyog Dhakras	Specialty Advisory Committee chair
Dr Bernadka Dubicka	Co-opted Member
Dr Nicole Fung	Co-opted Member
Dr Ruth Garcia	PLN Chair
Dr Holly Greer	Chair of Faculty in Northern Ireland
Dr Amani Hassan	Chair in Wales
Ms Rhiannon Hawkins	Participation consultant
Dr Thomas Hillen	Medical Psychotherapy link
Dr Siona Hurley	Regional Representative in Wales

Dr Tina Irani	Elected member, Policy & Public Affairs Committee
Dr David Kingsley	Adolescent Forensic SIG
Dr Abdullah Kraam	Elected member, Policy & Public Affairs Committee
Dr Clare Lamb	Student Mental Health, Infant Mental Health
Dr Holan Liang	Elected member, NSPCC & Workforce
Dr Ashley Liew	Elected Member
Dr Elaine Lockhart	Faculty Chair
Dr Mark Lovell	CAIDPN representative, Intellectual Disability
Dr Jose Mediavilla	Elected member, QNCC representative
Dr Catriona Mellor	Sustainability Champion
Dr Tessa Myatt	Regional Representative in Mersey, CYP Coalition
Dr Monica Nangia	Regional Representative in the North West
Dr Guy Northover	Finance Officer, National GIRFT lead, QI representative
Dr Isabel Paz	PLN Chair
Dr Gabrielle Pendlebury	Regional Representative London Central and North East
Dr Fifi Phang	PTC Rep
Mr Nathan Randles	Participation consultant
Prof Paramala Santosh	Regional Representative in London South East, BACD, NCEPOD
Dr Kapil Sayal	Academic Faculty Link
Dr Raj Sekaran	Regional Representative in London Central and North East
Dr Jujinder Singh	Regional Representative in West Midlands
Dr Karen Street	RCPCH link
Dr Suparna Sukumaram	Equality Champion
Dr Laura Sutherland	CAFPEB Editor
Dr Louise Theodosiou	Elected member, Comms, social media
Dr Catherine Thomas	Perinatal Faculty link
Dr Sami Timimi	Elected member
Mrs Toni Wakefield	Carer representative
Dr Joanne Wallace	Run through representative
Dr Susan Walker	Elected member, medico legal
Dr Sophia Williams	Trainee Representative