Faculty of Child & Adolescent Psychiatry Executive Committee Newsletter

	Elected members	
Chair		
Elaine Lockhart	Omolade Abuah	Ashley Liew
	Philippa Buckley	Jose Mediavilla
Vice Chair	Rory Conn	Paramala Santosh
Alka Ahuja	Tina Irani	Louise Theodosiou
	Abdullah Kraam	Sami Timimi
Finance Officer	Holan Liang	Susan Walker
Guy Northover		

Co-opted members and observers

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Nicholas Barnes
Prathiba Chitsabesan
Amani Hassan
Anna Conway Morris
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Virginia Davies
Suyog Dhakras
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Catriona Mellor
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Nathan Randles
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Kapil Sayal
Helen Smith
Karen Street
Fionnuala Stuart
Suparna Sukumaran
Toni Wakefield
Joanne Wallace
Sophia Williams

In this issue

Louise Theodosiou

Welcome to this winter edition of the newsletter, I know that this has been another challenging year for the world as we cope with the pandemic. It is wonderful to see how networks of support have found ways of adapting and developing. Psychiatrists are uniquely skilled at managing unknowns and complexity. We can feel a sense of pride in the way that we have offered leadership to our teams and our peers at this challenging time. Do remember to be kind to yourself at this time, and to seek care if you need it.

This newsletter provides a celebration of the creativity and resilience of our faculty. We have much to be proud of, and I extend my thanks to all of my hardworking peers who have been working to support children and families in this complicated time.

This newsletter offers a mix of valuable updates, reflections on the nature of psychiatry and opportunities to connect with peers and share experience. Remember, this newsletter is here for you, do feel free to contact me if you have contributions you would like to make.

Finally, I would like to draw your attention to the College's first ever LGBTQ+ membership survey. This will be open until the 31st of January.

Dr Louise Theodosiou
Editor
louise.theodosiou@mft.nhs.uk

Contents

The chair’s column

Elaine Lockhart

Newsletter December 2021

Elaine Lockhart

It is an honour to introduce myself to you as the new Chair of our Faculty. I am a consultant in paediatric liaison psychiatry at the Royal Hospital for Children in Glasgow and have worked with the RCPsych in Scotland and Scottish Government over the past few years and was joint Chair of the Paediatric Liaison network. I would like to thank our former chair, Bernadka Dubicka who worked so hard and effectively on our behalf. She was supported ably by Jon Goldin as Vice-Chair and Alka Ahuja as finance officer and I would also like to thank them for their work also over the past 4 years. Those of you who attended our successful conference will have heard that Alka was awarded a MBE earlier this year for her remarkable contribution to the provision of digital health services across Wales. Happily, we now have her as our Vice-Chair and Guy Northover is our new Finance Officer. Bernadka and others have raised the profile of our Faculty within the College, particularly when it became clear how much the Covd-19 pandemic is adversely affecting children and young people’s mental health and the capacity of our services, as well as leading on work relating to the climate emergency and online harm affecting children and young people.

Since the last newsletter we have been working in different areas on your behalf. Our Faculty presented at the last RCPsych Council meeting which allowed us to update colleagues on the current challenges facing children and young people with their mental health and the impact on our profession and services. I’m glad that they have agreed to consult young people regarding Council business and along with our Participation group, we plan to develop further how to bring the voice of children and young people and their parents/carers into the work of the College.

We have had excellent support from Policy advisers who are helping us to finalise and publish the report on mental health provision of 0 – 25 year olds which will focus on what is needed to support better transitions between mental health services and how best to meet the needs of 18 – 25 year olds in young adult services. There will also be work next year to develop a RCPsych cross faculty paper about 0 – 5 year olds which will connect to a report about our role in specialist CAMHS and what is needed for 5 – 18 year olds from specialist mental health services, in the context of better community based preventative and early intervention provision.

It is difficult to consider our current services and what is needed for further developments without thinking about workforce. Dr Kate Lovett, our former Dean, is now the College's workforce lead and there are different of activities in this area. The Choose Psychiatry campaign is building on its success in getting recruitment to core psychiatry to 100% and will now also focus on our higher training recruitment. This is just over 80% at the moment for CAP and the pilot run through training programme has been very successful, but we need to get this to 100% and we will need additional training posts to meet the needs of children and young people. There is also ongoing work with colleagues in NHSE and HEE to think about how to address the current medical staff vacancy rate of 17% in specialist CAMHS, which is being mirrored across the UK. It's become clear how much we need to think about how we retain colleagues in our specialty. We know that demands on our services have increased greatly and this has been putting pressure on us all especially in the context of the Covid pandemic. Although our work is so rewarding, it can feel overwhelming and many colleagues are looking to reduce their hours or change where they work. We are linking in with current College work regarding Diversity, Equality and Inclusion and Wellbeing which is relevant to this and we are also thinking about how we might create supportive structures for new and existing consultants and speciality grade doctors, building on what has been developed for new consultants with the Start Well and mentoring programmes.

We have been working with other Colleges particularly the RCPCH and many of you will have heard Karen Street, the RCPCH Officer for mental health at our conference who has been working with us and other colleagues to improve services for children and young people in paediatric and acute adult healthcare settings, both for those presenting as emergencies and also for those who need input in a planned way. Again, having a trained and supported workforce is key and there is ongoing work regarding mental health training for paediatric clinicians, as well as work to develop hospital-based liaison psychiatry services. Colleagues from the Paediatric Liaison network have been working hard to support a NHSE Task and Finish group regarding these challenges. A joint position statement from the RCPsych, RCPCH and the RC of Emergency medicine which emphasises that children and young people with mental health needs in acute healthcare settings are all of our patients is being worked up.

Linked to this is the reality that many of these children and young people will have been adversely affected by their developmental vulnerabilities and social circumstances and rather than just a mental health response, input from colleagues working in Education and Social Care can be key. To this end, a letter which was first developed by colleagues in Devon is being worked up within the College to be sent to Sajiv Javid to highlight the importance of recognising and addressing the social determinants of mental disorder, as well as the need to avoid over-medicalisation of emotional distress, especially in the context of the pandemic and associated restrictions. Colleagues in the devolved nations have also been approached about sending an amended version of this letter to their ministers who hold responsibility for mental health, since these challenges are being played out across the UK. There are opportunities with the move towards integrated health and social care services and I would urge you to work with colleagues locally to ensure that children's mental health is being considered within these arrangements.

There is a new College development with the establishment of the RCPsych Public Mental Health Implementation centre, which will be launched in the New Year and the Early Years will be one area of focus.

Another important piece of work being is the development of a position paper about Personality Disorder in young people which leads on from the RCPsych all age paper on this topic from last year.

I had the opportunity to attend COP 26 in Glasgow and heard directly from representatives of communities which are being directly affected by the climate emergency right now and from scientists and health professionals about current and future the impact on our physical and mental health. As a College we will be working together to press for more action from governments and large corporations, but I came away with a better understanding of how we all need to make changes individually, within our services and as an organisation to reduce our carbon footprint.

A key role for us is the development of information resources for colleagues, families, teachers and the general public. Early next year members of our committee will join colleagues in the College to think about how we can improve our communications via our website, Twitter, media work, resources development and our newsletter.

Finally our main ways of communicating with our members is through the regional reps and the devolved nations' chairs, our website and newsletter. Please get in touch if there are particular areas of work in which you would like to become involved.

It's been a busy and productive 6 months which is only possible because of the hard work and enthusiasm of our excellent committee members which you will be able to read about in this newsletter. We also owe our tanks to the wonderful Catherine Langley, our committee manager who keeps us all on track. We have just lived through another year which has been overshadowed by the pandemic and I am aware that some of you will have lost family and friends to Covid, either here in the UK or in other parts of the world. I really hope that you can all take some rest over the festive season and wish you all the best for 2022.

Elaine Lockhart
Chair, Faculty of Child & Adolescent Psychiatry
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Report from Scotland

Helen Smith

CAMHS update Scotland

At the Chartered Institute for Public Relations Scotland awards the RCPsych in Scotland's No Wrong Door campaign came away with the Silver Award for Best Public Affairs Campaign. In what was an incredibly strong field, it's a really positive reflection on the advocacy efforts of the College ahead of May's Scottish elections, with all five of our key priorities adopted by the Scottish Government into policy.

The faculty in Scotland continues to have input into a number of national processes including

- The Scott review of Mental Health Legislation to examine the issues with child and young people
- Continued input into the National Eating Disorders Implementation group with CAMHS and GAP colleagues
- Working with colleagues from England re position statement in regard to PD in adolescents

We have also responded to consultations regarding the National Care service, Physical intervention in schools guidance and the Veterans Mental Health Action Plan.

We had a Joint conference with GAP and ID colleagues 1st October 2021 which was well attended.

The CAMHS Faculty in Scotland continue to be very busy with media requests; between August and October 2021 14 pieces of coverage were completed with a reach (opportunities to see) of around more than 2.5m. We continue to try and get our message to as wide an audience as possible.

SAVE THE DATE

The CAMHS faculty in Scotland has secured a conference for next year with a provisional date of 23rd November 2022. Keep it free and we hope to see you there.

Helen Smith
Chair of the Faculty in Scotland
c/o Catherine.Langley@rcpsych.ac.uk

Report from Northern Ireland

Mark Rodgers

Faculty activity

Care and Justice Campus Submission

RCPsych met with CLC and DoH - case examples provided to allow a ‘working through’ of issues posited with full enactment of MCA, existing legislation and creation of care and justice campus.

Mental Health Strategy 2021-2031

NI College proactive in its dealings with the DoH. Previously submitted response to the DoH’s consultation on the Mental Health Strategy. Strategy was released June 2021.
Theme 1: Promoting mental wellbeing, resilience and good mental health across society
Theme 2: Providing the right support at the right time
Theme 3: New ways of working

Mental Health Strategy Funding plan

DoH commissioned Deloitte to undertake a research project to provide the foundation for the estimated costs to deliver the Strategy over its 10-year period and to understand the extent and range of resources required

Mental health services in NI have historically been underfunded when compared to other jurisdictions. For example, it is estimated that funding in NI is 27% less than in England and 20% less than in Ireland. That is even though the mental health need is assessed as up to 25% higher here than in, for example, England
The Funding Plan identifies a significant investment need, estimated at:

£112m to £158m revenue funding per annum
£285m one-off capital investment

Transitions’ consultation

DoH locally undertaking a review of CAMHS-AMHS transition arrangements and exploring various options for improving this process. CAMHS Faculty representation on that group.

Action Mental Health

Faculty working with AMH regarding creation of a youth panel. AMH coming to speak at next Faculty meeting.

Autism (Amendment) Bill

NI Assembly Committee for Health requesting views on the Autism (Amendment) Bill. The purpose of the Bill is to strengthen and enhance the Autism Strategy through amendments to the Autism (Northern Ireland) Act 2011.

BHSCT IMH Area Strategy

Belfast Health and Social Care Trust launched the Belfast Trust IMH Area Strategy (2021). Builds on themes from the Regional Infant Mental Health (IMH) Framework for Northern Ireland (Public Health Agency, 2016)

10th Joint Meeting of UPS/RCPsych CAPF 1.10.21

- Lifespan theme
- Started with focus on Neonatal and Early Childhood matters
- First keynote from NI's Mental Health Champion Siobhan O'Neill
- Second keynote from former RCPsych UK President Mike Shooter
- Alka Ahuja took us through some digital innovations
- Adolescent matters including acute mental health presentations, neuropsychiatric presentations and ED presentations

Mark Rodgers
Chair of Faculty in Northern Ireland
c/o Catherine.Langley@rcpsych.ac.uk

Report from Wales

Amani Hassan

Greetings from the Faculty of Child and Adolescent Psychiatry Wales, I hope this newsletter edition finds you and your loved ones all well in what has been another tough year. Firstly, I would like to thank you all for the warm welcome on my return to finish my term as faculty chair in Wales. I look forward to continuing to work with you all, especially at this testing time for mental health services nationwide.

However, before we get down to business and update on our activities as we bid farewell to 2021, this October saw the sad passing of the late Sir Michael Rutter, CBE FRS FRCP FRCPsych FMedSci (15 August 1933 – 23 October 2021). Undoubtedly one of the most decorated and influential psychiatrists of our time and a long time friend and supporter of the Academic Department at Cardiff University, he will be badly missed.

Left to right, myself, The late Sir Michael Rutter and Prof. Anita Thapar in 2019 at the Institute of Psychological Medicine and Clinical Neuroscience, Cardiff University.

Attended in November a virtual workshop arranged by People & Work organisation with a group of professionals from various backgrounds. The organisation has been commissioned by Welsh Assembly Government (WAG) to review the current demands, capacity and settings of neurodevelopmental services (NDD) for children, young people and adults in Wales in order to develop recommendations for improvement to services. Discussions were around sustainability of current NDD services as demand exceeds supply/capacity, with the pandemic adding another strain to the service. The demand is high even though the current services deal only with assessment/screening of ADHD and ASD as they had to stop post diagnostic service in most service to cope with growing demands.

As the mental health of children and young people continues to be severely impacted during the pandemic, the Policy team in RCPsych Wales, Prof. Alka Ahuja and Mr Ollie John, have met with the Minister for Mental Health and raised present challenges in sCAMHS. There will be a follow up meeting to address workforce pressures and recruitment. Furthermore, through the Academy of Medical Royal Colleges Wales, they both also met with the Minister for Health and have provided written information on eating disorders and anti-obesity messaging that was requested.

Last but not least, waiting list initiatives have been proposed and started in some areas as a quick fix/interim solution to both NDD and sCAMHS long waiting times, however sustainability and finding a long-term solution continues to be an issue.

Report from Wales

Cynefin {ki-neh-vin}: Habitat, Place or Belonging

The sense that we all have multiple pasts of which we can only be partly aware: cultural, religious, geographic, tribal etc.

On 22nd October, the Royal College of Psychiatrists Wales held its first **Sustainability, Climate Change and Mental Health** Conference.

The conference was held with the support of BJPsych Bulletin and was chaired by Delyth Jewell MS, Plaid Cymru spokesperson for Climate Change, Energy and Transport.

The conference was a collective of clinicians, academics, activists, politicians and young people explore the possibilities and need for change to mitigate the impacts of the Climate and ecological emergency.

The Conference recording & resources are available to view on demand.

> "As a young person representative for the organisation, Technology Enabled Care (TEC) Cymru (a Welsh Government funded national digital service), I was invited to participate in the conference along with other young people. We shared our views and concerns about the impact of COVID 19 on our environment through a debate.
>
> The session included the debate conducted by me along with some of the members of the young advisory group, TEC Cymru. The second part presented a video developed early in the pandemic by young people across Wales (ranging from two years to 23 years old).
>
> Young people advisory panel debate: COVID-19 & the environment
>
> I think the impact on our environment during the pandemic is an important matter because as young people it not only can affect our physical health but also our mental health and wellbeing."
>
> Ansh A, Young Person Advisory Panel, TEC Cymru

An outcome of the conference was a commitment to the establishment of a Cross Party Group in the Senedd on Climate Change, Nature and Wellbeing. This will be hosted by the College. There was further commitment that these issues need to be challenged across political parties with the voice of young people at the heart.

> "I'm hugely grateful for Ansh, Ebony and Abbie for the contribution to the event that they've given. It was their views and skill in debate and presentation that have informed ministers and officials on the eve of COP26. Informing and inspiring debate in our national parliament, the Senedd."
>
> Ollie John, RCPsych Wales Manager

Oliver.John@rcpsych.ac.uk

Far Away From Home

Kapil Sayal

FAR AWAY FROM HOME

NIHR | Applied Research Collaboration East Midlands

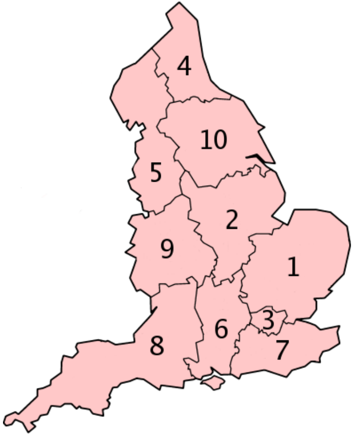
"Far Away from Home" is a mixed-methods study investigating the scale and impacts of far away, out of region or adult psychiatric ward admissions for 13-17-year-olds. Funded by the NIHR and led by Professor Kapil Sayal (Nottingham), it reflects a collaboration with regional teams across England including: East of England, East Midlands, West Midlands, Oxford & Thames Valley and the North West.

The study consists of 3 main components:

1) **Quantitative**
   - CAPSS Surveillance Study of far away, out of region or adult ward admissions
   - Investigation of NHS England data
2) **Quantitative**
   - National Interviews with Child & Adolescent and General Adult Consultants across England
   - Regional Interviews with young people, parents and professionals

Progress so far:

- Over 180 cases reported to CAPSS
- 25 interviews completed with Consultants from across England
- 20 regional interviews completed with young people, parents and professionals



1.East of England
2.East Midlands
3.London
4.North East
5.North West
6.South Central (Oxford/Bucks/Berks/Hants/IoW)
7.South East (Kent/Surrey/Sussex)
8.South West
9.West Midlands
10.Yorkshire & Humber

How can I get involved?

Reporting cases:

- Please let us know if you or a member of your team, including when on-call, have seen any eligible cases (e.g. either for an assessment or for ongoing clinical care) **Eligibility criteria:** The young person (aged 13-17 years) has been admitted since February 1st 2021 to either**:**
  - ○ **a CAMHS General Adolescent Unit (GAU) over 50 miles from their home address**
  - ○ **or a CAMHS GAU outside their NHS region (as shown on map)**
  - ○ or an adult psychiatric ward
- You can report this either through your monthly CAPSS e-card or, if the case is from a previous month, by directly emailing us at faraway@nottingham.ac.uk

Qualitative Interviews:

- We are very keen to interview General Adult psychiatrists (or ward nursing leads) who have looked after an under-18 on their ward.
- Please let us know if you know a colleague whom we could approach.

Support and Follow the study:

- Data from NHS England suggests the possibility of under-reporting of cases through CAPSS. This risks under-estimating the true scale and extent of this issue.
- To raise awareness of the study, please follow/tweet **@FarAwaystudy** or email faraway@nottingham.ac.uk to sign up to our newsletter.

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

CAPSS Autumn Newsletter

CAPSS Newsletter

CAPSS Autumn Newsletter

Autumn hopefully will find you back to some normality, CAPSS despite three lockdowns has been meeting virtually and we have two new studies on the cards which are both very relevant and timely given all the changes that Covid has brought.

Study Updates

Far Away From Home -New Surveillance study

At present, we know little about the young people who are admitted far away from home or to adult wards, how many are affected, the impact it has and what clinicians feel about this. Through CAPSS, we are aiming to establish the extent of admissions to general adolescent units at distance from home or to adult wards. Specific objectives of the study are to:
Find out the numbers of 13-17 year olds admitted to general adolescent units at distance from home or to adult psychiatric beds.
Describe the characteristics and initial outcomes of the young people affected.
Gain a better understanding of the experience of and reasons for such admissions from the perspective of child & adolescent psychiatrists (and, via a linked separate qualitative study, the impact of such admissions from the perspectives of the young person, their parents/caregivers, community and inpatient clinicians (CAMHS & AMH), and NHS commissioners.

How to report?
If you are a community or inpatient Consultant, please report cases through your monthly CAPSS e-card (electronic “yellow cards” received by email). If you are not a Consultant but have seen an eligible case, please make your team Consultant aware of the case to facilitate reporting of the case. This study started February 2021.

ARFID – New Surveillance Study

This is a joint study between the British Paediatric Surveillance Unit (BPSU) and the Child and Adolescent Psychiatric Surveillance system (CAPSS) looking at the incidence of **Avoidant Restrictive Food Intake Disorders.** ARFID is conceptualised as an umbrella term to include a range of eating and feeding disturbances that lead to nutritional deficits and/or impairment of psychological functioning, as a result of food restriction.

The study aims to establish incidence rates (number of new cases) of ARFID presenting to secondary health care, referral pathways, patterns of presentation, and clinical features (eating behaviours, medical complications and the types of medical or psychiatric presentations it is associated with). This will allow us to compare rates, presentation and management of ARFID with other countries, as well as generating new priority research questions that could in turn inform decision making to better match patient need with sufficient funding allocations. We hope the study findings will prompt further research on causality, treatment, prognosis, and long-term outcomes of ARFID. This study started March 2021.

Sydenham's Chorea

The first phase of the Sydenham's chorea (Sc) surveillance study is now complete, and the research team is grateful to all Child and Adolescent Psychiatrists who responded to CAPSS.

The study continues with follow up data being requested from paediatric colleagues who have reported cases. The finding that no children with Sc were reported from CAMHS clinics is important and requires further exploration. Sc is associated with increased incidence of a range of mental disorders that might lead to CAMHS input. It is particularly striking that Sc has not identified at a time when related post-streptococcal disorders (PANS/PANDAS) are increasingly being recognised.

The research team is looking for comments from Child and Adolescent Psychiatrists with ideas about why CAPSS found no cases of Sc. If you have any ideas about this (any length of comment is welcome), please send an e-mail to the Principal investigator, Dr Oana Mitrofan at O.Mitrofan@exeter.ac.uk.

Impact

Involvement of community paediatricians in the care of children and young people with mental health difficulties in the UK: implications for case ascertainment by child and adolescent psychiatric, and paediatric surveillance systems
Hani F Ayyash, Michael Oladipo Ogundele, Richard M Lynn, Tanja-Sabine Schumm, Cornelius Ani
Published February 2021 in the BMJ Paediatrics open, http://dx.doi.org/10.1136/bmjpo-2020-000713

CAPSS Webinar -COVID-19 and Eating Disorders in Childhood and Adolescence.
Dasha Nicholls presented a hugely successful webinar July 2021 that was very well received and covered the recent surge in eating disorders cases through covid and also looked at ARFID in more detail which is linked to the on going CAPSS study .

Website

Please do take a look at our website as it gives a good overview of our current and previous work. We hope you will find the information you need easily.
https://www.rcpsych.ac.uk/improving-care/ccqi/research-and-evaluation/current-research/capss

CAPSS Executive Committee Updates

We sadly said good bye to Michael Morton from the committee. Michael has contributed significantly to the committee over many years. His eye for detail and precise articulation will be sorely missed in our meetings. Michael is looking forward to retirement away from zoom meetings. We wish him well and thank him for all he has contributed to CAPSS.

We welcome new members to the committee: Siona Hurley (Northern Ireland representative), Helen Smith (Scottish representative), Alka Ahuja (Welsh representative), Tamsin Newlove Delgado (Public Health), Ian Wong (Pharmacology) and Joanne Doherty (new trainee). We also want to also welcome a new team of administrators from the college Gavin Herrington, Kulvinder Wariabharaj and Robert Low who support all the work we do.

Consultants returning e-cards

The responses of CAMHS consultants as to whether you have seen any cases of the rare disorders advertised is fundamental to the success of the surveillance system. REMEMBER that a “No I have not seen a case” response is as important as a positive report, so that we can establish a response rate. If you do not fill in the survey, we do not know if you did not see a case or did not receive the e-card.

Contact details of consultants

Having up-to-date contact details for consultants who take part in the active surveillance is essential to ensuring that researchers can contact the consultants who have notified CAPSS that they have seen a case of one of the rare disorders. Please ensure that we have the correct work contact details and email for you by contacting us on CAPSS@rcpsych.ac.uk

Certificate of participation in research

If you have contributed to CAPSS studies you can request a certificate of participation in research from CAPSS and this will be emailed to you, contact us on CAPSS@rcpsych.ac.uk

CAPSS Executive Committee

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

CAMHS Professionals needed for EnCAMHS Study

We’re asking CAMHS professionals and key referrers into CAMHS, including GPs, to take part in an online focus group to share their opinions on the current CAMHS referral pathway as part of an NIHR funded research project to Enhance the CAMHS Referrals process (EnCAMHS).

We know there are some challenges with the CAMHS referral pathway, with around a quarter of children and young people who are referred ultimately not being offered treatment through CAMHS. This is distressing for children and their families, as well as being burdensome on staff time. The EnCAMHS project aims to understand what the difficulties are in making referrals to CAMHS services. We want to improve the quality of referrals to CAMHS so that only children and young people who can be helped by CAMHS are referred; and so that others can be guided to receive help they need elsewhere.

It is essential we hear from the professionals who regularly face these challenges, and their opinions are invaluable when suggesting potential solutions to any problems identified.

We are holding focus groups for key referrers and CAMHS staff on the following dates, if you are able to attend one:

- Fri 28th Jan, 12:00-13:00
- Thurs 3rd Feb, 16:00-17:30
- Thurs 10th Feb, 12:00-13:00
- Thurs 24th Feb, 11:00-12:30
- Thurs 3rd March, 16:00-17:30

If anyone is interested or would like more information, please do get in contact:
zara.bernard@manchester.ac.uk

Paediatric Liaison Network Update

Virginia Davies

Dear Readers

Since it has been a while since I provided a newsletter update, I will endeavour to cover rather a lot in a short space

Our members have been active in many different fora, namely meetings with NHSE, HEE, various groups within RCPCH, various groups within the College and with the Advanced Life Support Group (ASLG) – why they, you might ask? And we shall return to this later

Just to expand on the various groups within groups, within RCPCH, we have Elaine Lockhart, Prathiba Chitsabesan and me, on occasion, sitting on the Mental Health in Acute Settings Advisory Group (MHAG), Rory Conn on the Emergency Standards Committee (responsible to the cycle of updating the Facing the Future standards https://www.rcpch.ac.uk/resources/facing-future-standards-children-young-people-emergency-care-settings), Rory, Birgit Westphal and Sophia Williams sitting on the Paediatric Mental Health Association (PMHA https://pmha-uk.org/tag/rcpch/) executive and Sujog Dhakras liaising with RCPCH over the development of their mental health SPIN – special interest in –for paediatric trainees. Within our College, Birgit and I sit on the Liaison Psychiatry (LP) Faculty executive, Birgit is on the Psychiatry Liaison Accreditation Network (PLAN) accreditation committee and I am on the PLAN Advisory Group. The PLN is represented by me or Isabel Paz, our vice chair, at the Child and Adolescent Psychiatry Faculty executive or LP executive. Our trainee reps Sophia Williams and Ashy Rengit have been active making links at trainee level with trainees in other Colleges, as well canvassing exposure to and knowledge levels about paediatric liaison psychiatry within our College's trainee membership.

Karen Street, mental health lead at RCPCH, is involved in many of the groups and is a really pivotal and committed advocate and support of much of this work.

The main thrust of all the meetings that Karen and our members attend is to

1. To drive up standards of care in emergency and routine settings via
2. Lobbying for better access for CYPF and staff to child and adolescent psychiatry expertise within acute care settings, whether in emergency settings, on wards or in outpatient clinics
3. Supporting greater, or ideally routine, access for acute care staff to high quality learning and training in paediatric mental health competencies
4. Sustain meaningful and productive relationships with key players (NHSE, HEE, Colleges, NICE committees, patients, public & the voluntary sector PPV) in order to effect the delivery of safe, high quality integrated mind-body care for CYPF

In order to achieve these aims

- Prathiba, in her NHSE role, has been working on the NHSE mental health clinically-led review of standards led by Stephen Powis and Claire Murdoch National and will no doubt be feeding back on these direct within this newsletter or the next.

- Birgit has been working with the NHSE Task and Finish Group to support them in considering various models of service delivery and the evidence for each. The group's intention is to publish exemplar models (including training)for commissioners and providers, as well as self-assessment tools.

- Elaine and Karen have been liaising at a national level to provide the key information, metrics and evidence of need vs current poor capacity and level of training needed by NHSE/I and HEE. These have resulted in plans to provide online learning for acute care staff.

- Rory, Birgit and I have been feeding into the updating of the RCPCH and RCPsych standards, not least the revision of PLAN standards, the latter which will soon be out for consultation.

- The RCPCH MHAG has been contributing to developing an NHSE/I framework for systems to support improved integration, through joint leadership, and is soon to publish a position statement signed by all professional groups working with CYPF with mental health needs in hospitals. NHSE/I are heavily alive to the ASD/LD considerations that need to be made with any of their proposed models for acute care: place of sanctuary, liaison teams, paediatric mental health assessment units. I paste in the workstream infographic at the end of this report, as well as Karen Street's more detailed feedback to the CAP Executive, which includes this and other relevant updates.

- I have fed back, in consultation with members, on various processes: in August the RCPsych liaison credentialing work which is being developed for in line with the GMC's credentialing framework https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/credentialing ; in November, the proposal to give powers in legislation to health professionals in emergency departments, so that they can detain patients in need of urgent mental health assessment. This work rests with policy advisers at the Department for Health and Social Care.

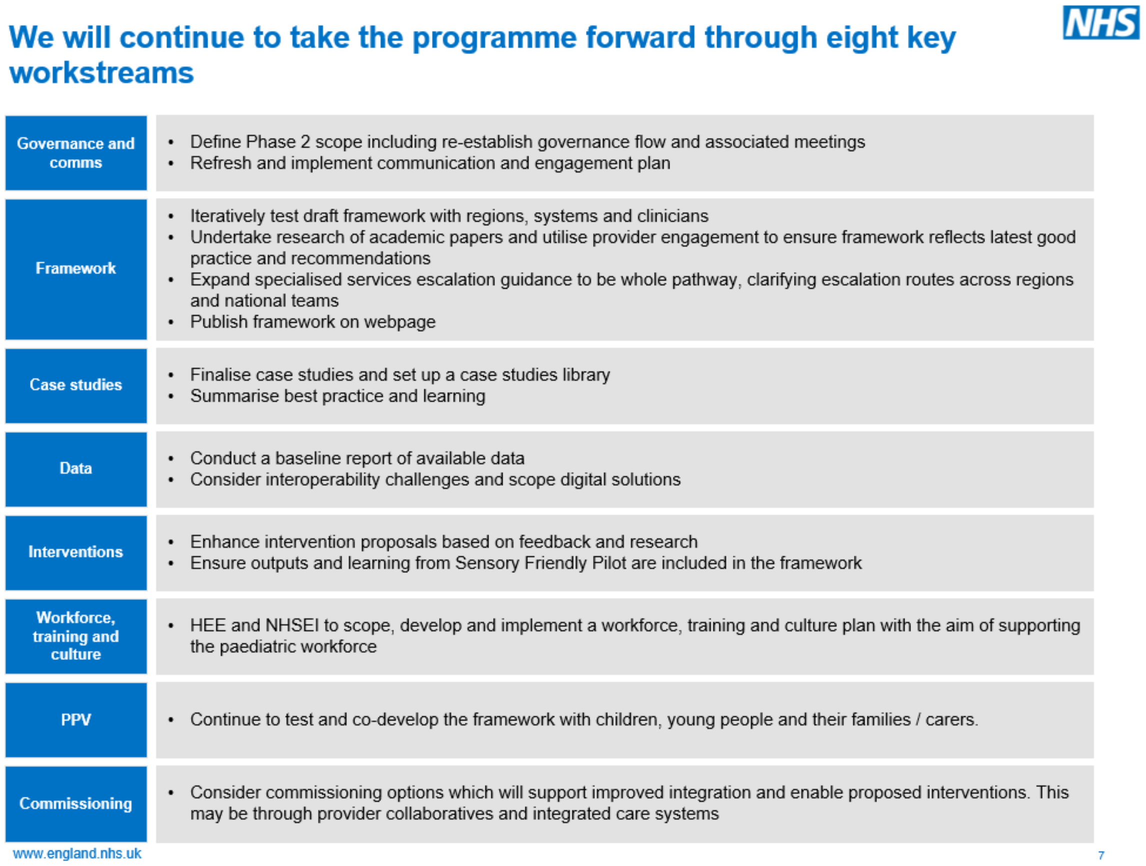
- I have been working with ALSG to further develop for under 18s their APEx (acute psychiatric emergencies) training materials for use in simulation training for all staff working in emergency setting, including paramedics https://www.alsg.org/home/course/view.php?id=212

An important future date for your diaries is in January next year, when the revised NICE self-harm guidelines will be put out for consultation. Responding to these with support or reasoned arguments against proposals will be very important, not least as these standards have knock on effects for other standards, most directly the PLAN https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/psychiatric-liaison-services-plan/quality-standards-for-liaison-psychiatry-services---sixth-edition-20209b6be47cb0f249f697850e1222d6b6e1.pdf?sfvrsn=1ddd53f2_0 and RCPCH emergency standards

Anyway, I could spend all day feeding back even more, but I must move my body, go and get some fresh air and have a swim – it's my day off! So I'll sign off here, wishing you all a safe and happy festive period

Virginia Davies

Chair RCPsych Paediatric Liaison Network



We will continue to take the programme forward through eight key workstreams

Governance and comms	• Define Phase 2 scope including re-establish governance flow and associated meetings • Refresh and implement communication and engagement plan
Framework	• Iteratively test draft framework with regions, systems and clinicians • Undertake research of academic papers and utilise provider engagement to ensure framework reflects latest good practice and recommendations • Expand specialised services escalation guidance to be whole pathway, clarifying escalation routes across regions and national teams • Publish framework on webpage
Case studies	• Finalise case studies and set up a case studies library • Summarise best practice and learning
Data	• Conduct a baseline report of available data • Consider interoperability challenges and scope digital solutions
Interventions	• Enhance intervention proposals based on feedback and research • Ensure outputs and learning from Sensory Friendly Pilot are included in the framework
Workforce, training and culture	• HEE and NHSEI to scope, develop and implement a workforce, training and culture plan with the aim of supporting the paediatric workforce
PPV	• Continue to test and co-develop the framework with children, young people and their families / carers.
Commissioning	• Consider commissioning options which will support improved integration and enable proposed interventions. This may be through provider collaboratives and integrated care systems

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Karen Street’s feedback

Key items to note:

1. NHSEI CYP Mental Health/Physical Health Task and Finish Group

2. Joint Royal College discussions with NHSEI

3. Mental Health Advisory Group meet with HEE

NHSEI CYP Mental Health/Physical Health Task and Finish Group

· NHS England’s CYP Transformation Team and CYP Mental Health teams have established a task & finish group focused on supporting CYP with mental health needs within acute and paediatric settings

· Group membership is drawn from paediatrics, nursing, emergency medicine, psychiatry, NHSEI CYP, Learning Disability & Autism, CYP MH, and HEE. NHSEI also establishing user/CYP input for the work.

· The focus is on building a framework for systems and regions that prompts greater collaborative working, signposting training opportunities, scoping potential innovative service developments, and developing a maturity matrix for systems.

· As well as progress on Mental Health Lead Roles in paediatric departments (a key recommendation in RCPCH 2020 position statement), we hope to see development around age appropriate mental health liaison services for CYP in hospitals. Joint Royal College discussions with NHSEI. Significant overlap with this and the above but significant output will be a joint college statement re 'everybody's business', 'right time right place' (in final draft) RCPsych, RCEM, RCPCH, approached NHSEI Mental Health and CYP leadership, with reps from HEE for a 'summit' on current CYP MH issues. This took place in late August and covered service capacity, strengthening pathways, and training & workforce.

· While the Long Term Plan will play a role in addressing some of the issues currently experienced in paediatrics and CAMHS, there was an openness to actively exploring other ideas such as paediatric liaison services and mental health leads, noting that workforce and commissioning implications would need to be considered upfront if they are to be successful, and if the potential that ICS offer may be realised. This all remains 'work in progress', but we are encouraged by the appetite within NHSEI for addressing the issues we've seen in paediatrics, particularly since the start of the pandemic, and we are benefitting from good working relationships with RCPsych on all this. MHAG meet with HEE Recent meeting centred around workforce training to address all the above. HEE presentation re plans. Focus groups and expert reference groups will take this forward. Using this meeting and others to push forward jointly with RCPsych and RCEM potential for a CYP version of the APEX ALSG course.

Finally: Ongoing workstream with RCPsych and RCPCH meeting separately to discuss joint training opportunities (Suyog). RCPCH currently mapping our training pathway alongside mental health competencies to support these discussions.

All for information only. RCPCH will continue to work closely with Elaine and RCPsych individual reps to ensure we work closely as colleges with joint objectives and a unit

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Infant Mental Health

Dr Fionnuala Stuart
Dr Fiona Lamb

Welcome to the second of what we hope will be a regular Infant Mental Health section in the faculty newsletter. Firstly, many thanks to those who completed the Parent Infant Foundation's survey on provision for infants and their parents/carers in CAMHS in the UK highlighted in the last newsletter. Below is a link to the report on the survey's findings. In summary, "only **9%** of respondents felt there was 'sufficient provision available for babies and toddlers whose mental health was at risk' in their area" with many adding comments regarding the lowest age of referral accepted by their CAMHS service such as "Rare to see children under 7 even though service spec is 0-18 yrs". It is well worth reading the full report and recommendations and there are many other helpful reports, toolkits and infographics relevant to Infant Mental Health on the Parent Infant Foundation website.

PIF-Where-are-the-Infants-in-CYP-MH-26-May.pdf (parentinfantfoundation.org.uk)

In response to this gap in CAMHS provision, Fionnuala is setting up an email discussion group (along the lines of the paediatric liaison network email discussion group) for child psychiatrists (consultants, speciality doctors and all training grades welcome) with an interest in infant mental health and CAMHS provision for 0-5 yr olds and their parents/carers. It is hoped that this will be a forum for sharing relevant research and training opportunities, service developments and clinical good practice. While infant mental health, like all mental health, is very much a multidisciplinary task, this forum will be for psychiatrists only (like the paediatric liaison network forum), certainly in the initial stages. Through the discussion group, information will be provided about the various multidisciplinary infant mental health fora already in the UK and further afield, including organisations of parents and carers with lived experience. However, it seems helpful at this point to have a space to think, debate and share experiences on the potential role of the child psychiatrist in infant mental health provision and how this might relate to other specialities and disciplines such as parent-infant psychotherapy, paediatrics, and adult psychiatry, including perinatal.

If you would like to join this email group, please email: Catherine.Langley@rcpsych.ac.uk with the heading 'Infant Psychiatry Group', briefly describing your current job and training level and where you are based, and using your preferred email for the group, and she will forward to Fionnuala.

Finally, to inspire you regarding what good infant mental health provision within CAMHS can look like and spark ideas for training and career development, Fionnuala interviewed Associate Professor Campbell Paul, Consultant Infant Psychiatrist in Australia, and past president elect of the World Association of Infant Mental Health (World Association for Infant Mental Health (waimh.org)).

You are a Consultant Infant Psychiatrist at the Royal Children's Hospital and Royal Women's Hospital in Melbourne, Australia. Can you describe a typical clinical day in this post?

I have been at the Royal Children's Hospital for many years and have seen the evolution of the infant mental health program over this time where there is a hospital and community child and adolescent mental health service which is embedded within a paediatric hospital. It has strong links to developmental and psychoanalytic understandings of infant and infant parent relationships, and a clinical basis of applied attachment theory and family therapy. In addition to the hospital consultation liaison infant program, we have three community infant mental health teams.

In my day-to-day work in hospital consultation liaison infant mental health, I see infants, toddlers and pre-schoolers who are hospitalised or frequently attending the hospital with severe medical or surgical problems. A typical day starts with a morning catch up to plan the day (currently an online meeting). Our hospital IMH team consists of the senior psychologist IMH program coordinator, a senior child psychiatry trainee and a paediatric trainee each doing an infant mental health rotation, and me. The infant mental health program is an integral part of many of the hospital clinical services from the neonatal unit to general paediatrics, cardiology, respiratory services, oncology, maternal health and other specialties. We work closely with our paediatric medical and nursing colleagues, clinical psychology colleagues and neuropsychology, social work, speech pathology, music therapy, play therapy and other disciplines. At any one time we usually have around 15 babies and young children whom we are seeing directly, and in consultation with their primary care team. We receive referrals from any of the hospital units, but, in particular, general paediatrics, cardiology and respiratory services and the neonatal and paediatric intensive care unit.

One important part of our program is the Thursday neonatal intensive care mental health ward round when we visit five or six babies and their parents in NICU to introduce the concept of infant mental health. Meeting the baby at the cot side, we gently explore the parents experience of mentalization of their baby within this often very traumatic context. It's amazing see the warm surprise expressed by parents when we can share with them how much their baby is aware of their presence, their voice, their touch and their capacity for play and engagement, despite their serious medical state. In this we use an adaptation of the Newborn Behavioural Observation (NBO) method of early infant-parent relationship building.

The infant psychiatrist is also an integral part of our teams in the community which receives referrals for infants and toddlers with major relationship and emotional disorders. I have regular secondary consultation to our Cradle to Kinder program providing family intervention for extremely vulnerable families where child protection is involved, and I meet with clinicians from adult and perinatal mental health in the public sector who are working with parents with severe mental illness. Our job is to help the parents, and the professional carers, keep the baby in mind.

Which parts of your training were most helpful in preparing you for working in infant mental health?

My understanding and passion for work with babies and parents was stimulated by paediatrician and amazing infant parent-psychotherapist, Dr Ann Morgan, at the Royal Children's Hospital, who showed me what babies could understand and what they could do, and how complex the infant-parent relationship could become. This led to me spending a marvellous sabbatical term in Cambridge with Lynne Murray and her research team at the Winnicott Research Institute (now at the University of Reading). I also learnt much from an attachment at the Tavistock Clinic where I met Dilys Daws, Juliet Hopkins and colleagues. I undertook a powerfully important infant observation which I think is an essential part of training for an infant psychiatrist. I also learned the Brazelton Newborn Behavioural Assessment Scale with Kevin Nugent in Boston, and in Paris spent time with Prof Antoine Guedeney and Prof Serge Lebovici. This period many years ago consolidated my interest in understanding in the baby as a person in their own right.

I believe I learnt much from my two years at the beginning of my career at the University of Edinburgh where I saw an enthusiastic and respectful conjunction of general psychiatry and psychoanalytic approaches to mental health. My supervisors and mentors in Melbourne enabled me to continue my learning about babies and young children and the complexities and subtleties of the infant-parent relationship. Subsequently I have been very involved in the World Association for Infant Mental Health, attending conferences and visiting clinical and research services in many countries. All of this has, I believe, deepened my understanding of well and troubled infants and what we can do as psychiatrists to help. This work can be very intense and taxing, and it is important I believe to have one's own attuned supervisors and colleagues and a psychotherapeutic experience as part of training. I've also been very interested in group psychotherapy interventions with infants and parents and can see the value in infant-infant interactions and the therapeutic support parents can provide each other and their babies.

Which are the most rewarding parts of your job?

What I find rewarding is when what may seem to be a simple or brief intervention for a distressed or withdrawn infant and sharing with parents an understanding of the baby as a person, can lead to a real and sometimes rapid change in the baby's state. It is very humbling to be able to help parents whose infants face life-threatening, and sometimes life-denying illness. Through direct engagement with gaze, voice, touch and especially play, even with the very sick baby, we can help parents know who their baby is, and be available to support them even in the most frightening of situations.

I'm also very inspired by working with my young colleagues and seeing their curiosity and commitment to understanding and providing treatment for young children and their families. I've also learnt very much from the use of video in therapeutic work and in teaching.

What do you find most challenging?

One of the most challenging parts of my work is knowing how difficult it is for infants and their parents to receive the sort of therapeutic intervention they deserve. In hospital work, and from the referrals to our community teams, we learn of the dire psychological predicament for many very young children. We know that even brief psychodynamic informed therapies over the course of several months can see the infant move to a much healthier psychological pathway. We can see how effective treatments such as infant-parent psychotherapy (e.g. Anna Freud Centre) and Child Parent Psychotherapy (CPP, Lieberman & Van Horn 2008) are, but there is so much more work to do to convince our service funders of the value of our therapies for infants and parents.

What do you think child psychiatrists can bring to multidisciplinary infant mental health teams?

There is increasing evidence for, and now awareness of, the importance of early life events and trauma in the evolution of subsequent child adolescent and adult mental health disorders. Not many years ago clinicians thought that primary school (and younger) children could not get "depressed" as they did not have the psychic apparatus to experience loss in the way that adults do. Clearly this is not true, and we can see that even infants in the newborn period can demonstrate that they experience depression, withdrawal, and emotional dysregulation. We know that childhood maltreatment is prevalent, and infants are increasingly exposed to severe family violence. Childhood maltreatment of very young children is a critical area where child psychiatry must be involved. In the face of trauma, infants show a range of defensive symptomatology which can profoundly affect their psychological, relationship, social and cognitive development.

Karlen Lyons-Ruth from Boston (Lyons-Ruth 2008, Khoury et a 2021) and colleagues have reported on longitudinal research which shows a clear linkage between early psychological and physical trauma and later adult psychopathology such as depression and anxiety, borderline personality disorder, dissociative disorders, and antisocial disorders. Using observational tools of parental behaviour, such as the AMBIANCE (Madigan 2003), we can identify problematic parental behaviours and what might underlie the parents' distress and then deliver effective psychological interventions.

I believe that the child psychiatrist has a responsibility to provide leadership and undertake thorough assessment, formulation, and treatment planning in respect of troubled infants and families. With our training in human development and psychopathology, we are well placed to understand the child's inner world and the relationship disorders they may experience. We must also bring the extensive learnings of family therapy to working with the preverbal child and their carers.

All child psychiatrists should have access to high-quality training in infant mental health and infant parent relationship assessment and treatment. As a child psychiatrist I value the opportunity to provide support and supervision for our child psychiatry trainees but also for trainees from any other disciplines. We have run a Masters program in infant mental health through the University of Melbourne, and this training continues through the state-wide child psychiatry training program, Mindful (Child and Adolescent Psychiatry Course (CAPC) - Mindful).

We already know much about what can work for whom, and the current generation of troubled infants, as well as future generations, deserve our commitment to increasing the availability of proper diagnosis, therapy and evaluative research.

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Research Project- Electronic survey on tics and tourette's in under 18s.

Katey Gribben

TIC TAC: Tics In Clinic, Treatment and Assessment Comparison

Tics and Tourette Syndrome are common childhood conditions and are seen by specialists working across medicine in paediatrics, paediatric neurology and CAMHS.

I am Katey Gribben and I am a ST5 CAMHS trainee and I am interested in finding out if young people receive any difference in their assessment or treatment when they are seen across these specialties. To answer this question, I am conducting a semi qualitative electronic survey which is multiple choice and takes less than 10 minutes to complete. If you are currently a specialty training doctor, specialty career doctor, trust grade or a consultant working in CAMHS OR Paediatrics OR Paediatric neurology you are eligible to take part. Response is anonymous and no patient identifiable information is requested.

Watch this space for the link to the TIC TAC Survey!

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

Determinants of psychological distress in mothers of children with autistic spectrum disorder and intellectual disability: A comparative study

Varun S Mehta, Deepika Lina Mina
and J. W. James

Abstract

Background: The presence of psychological distress has been reported among mothers of children with Autism Spectrum Disorders (ASDs) and Intellectual disability (ID). They undergo many emotional upheavals in their personal and social lives while taking extra care of their children. However, the comparisons among them have been done in a very few studies across the country.

Methods: This is a cross-sectional study that has recruited 15 mothers aged 21 to 50 years of children with ASD and ID each. Kessler Psychological Distress Scale (K10), Multidimensional Scale of Perceived Social Support (MPSS) and Life Orientation Test-R (LOT-R) were applied to determine the psychological distress, social support, and optimism in the mothers.

Results & Conclusion: Mothers of ASD and ID did not show significant differences in any of the clinical characteristics. However, it was found that involvement of grandparents in the treating process helped the mothers develop optimism in dealing with the situation.

Keywords: Psychological Distress, Autism Spectrum Disorder, Intellectual Disability.

Introduction

In India, ASD is thought to afflict more than two million persons, with a pooled percentage prevalence of 0.11 (1–18-year age group) in rural areas and 0.09 (0–15-year age group) in urban areas.

There can be multifaceted and pervasive effects on parents and families of having a child with ASD and ID. Additional physical, emotional, social, and financial resources are frequently required during the caring process. The challenge is compounded by the severity, chronicity, extensive developmental and physical co-morbidities, and difficulties in availability and accessibility of health services. Parents have the additional obligation of providing specialized inputs for overcoming the child's deficiencies apart from the regular child-rearing processes (Selvakumar & Panicker, 2020).

The practical problems like disturbed family relations, constraints in social relationships, work & leisure activities; and financial difficulties account for the objective burden whereas the caregiver’s psychological reactions like uncertainty, guilt, loss of hope, expectations, dreams, depression, anxiety, hate, anger, embarrassment in social situations constitute the subjective burden (Magliano et al., 2005). The ensuing caregiver burden is linked to substantial parenting stress when compared to families of child with typical development and to families of child with other difficulties. This increases the risk for mental health concerns and psychological distress (Hayes & Watson, 2013).

It has been recognized that mothers of children with ASD report higher levels of caring engagement, anxiety, stress, and depression of clinical relevance than fathers (Tehee et al., 2009; Falk et al., 2014). Khanna et al., (2011) found subjective burden in mothers of children with ASD that led to increased tendency towards depression. Selvakumar & Panicker (2020) reported depressive symptoms in 60.4 percent of the mothers and 46.2 percent were found to be anxious.

In the stress and adaption process of caring, perceived social support is an important coping resource. Perceived support from informal social networks, such as family and friends, has a direct impact on the mental health of mothers of children with ASD, as well as a buffering effect on the mental health of caregivers (Singh et al., 2017).

To the best of the knowledge of the authors, there have been no direct studies comparing the psychological distress among the mothers of children with ASD and ID. Since, both the disabilities could have a differing outcome and impact on the caregiving process, the current study aims to determine the domains of psychological distress in mothers of children with ASD and compare it to mothers having children with ID.

Methods

Participants

It was a cross-sectional study with purposive sampling conducted on 15 mothers of children with ASD and ID each matched for their age. The data was collected from the Centre of Child and adolescent Psychiatry, Central Institute of Psychiatry, Ranchi, Jharkhand. The permission was obtained from the

Institute Ethics Committee and written informed consent was acquired from the participants after explaining them the purpose of the study. The study was conducted as a part of dissertation work during the period from 2019-2020. ASD and ID were diagnosed on a clinical interview and evaluation by a competent psychiatrist based on ICD-10. The category of ASD is coded under the section of F84.0 (Pervasive Developmental Disorders) in ICD-10. A clinical psychologist's assessment score on the Childhood Autism Rating Scale (CARS) and the Vineland Social Maturity Scale (VSMS) were used to assess the degree of deficits in social functioning.

Materials

Kessler Psychological Distress Scale (K10) (Kessler et al., 2002) was administered to assess the psychological distress. It is a 10-item questionnaire with scores ranging from 10 to 50. Scores under 20 are likely to be well, scores between 20-24 are likely to have mild mental disorder, scores between 25-29 are likely to have moderate mental disorder, and scores above 30 are likely to have severe mental disorder.

The Multidimensional Scale of Perceived Social Support (MPSS) (Zimet et al., 1988) has three components of support which are from family, friend and significant others. This 12-item scale was applied, where higher scores indicate higher perceived social support.

The Life Orientation Test Revised (LOT-R) (Scheier et al., 1994), is a 10-item assessment of optimism versus pessimism; high scores meant greater pessimism and lower optimism.

The statistical analysis was done using the IBM SPSS version 25.0. Student t test/Mann Whitney U test were used.

Results

The mean age of the mothers of children with ASD was 29.80±5.00 years. They were better educated (p=0.009), hailed from a joint family (p=0.017) of an urban habitat (p=0.001) and a middle socioeconomic status (p=0.027). As expected, males predominated among the children with ASD (p=0.050). The children with ASD were significantly younger (p=0.001), with a mean age of 5.60±2.50 years and had a significantly lesser duration of symptoms (p=0.001). The mothers in both the groups did not differ in the levels of psychological distress, perceived social support and pessimism-optimism (Table 1). There was no significant correlation of the socio-demographic characteristics with psychological distress and perceived support.

Table 1: - Comparison of psychological distress between the mothers of children with ASD and ID (N = 30)

Variables		ASD (n=15)	ID (n=15)	U/t	p
		Mean Rank/Mean±SD	Mean Rank/Mean±SD		
K10		15.87	15.13	107	.838
MPSS	**Family**	4.60±2.44	5.12±1.46	-.704	.487
	Friends	4.40±1.71	5.12±0.53	-1.549	.133
	Significant others	5.33±1.53	4.97±1.38	.688	.497
LOT		23.40±3.91	24.20±4.11	-.547	.589

K10 = Kessler Psychological Distress Scale; MPSS= Multidimensional Perceived Social Support Scale; LOT= Life Orientation Test

Discussion

The study envisaged to assess and compare the components of psychological distress among mothers of children with ASD and those with ID. We found that the mothers in both the groups were likely to be well in terms of psychological distress. However, high levels of parenting stress and psychological distress have been found in the mothers of autism spectrum disorder as compared to developmental disorders (Tobing & Glenwick, 2007; Estes et al., 2009) previously. Some of the important socio-demographic characteristics could explain these observations.

The mothers of children with ASD were better educated with at least nine years of formal education. The residence in an urban habitat and socioeconomic background are the likely contributory factors. It is established that the burden of care is mostly on mothers, leading to high level of stress along with psychological and physical burden in their daily life. Equally surprising is the fact that the mother's educational background helps her understand her child's health condition, accept it and cope with an optimistic attitude. The optimism bolsters the mother and child develops a sense of bond (Rhoades et al., 2007; Al-Dujaili& Al-Mossawy, 2017).

A perceived lack of support from male partners and fathers results in mothers venting their emotional feelings of grief with anger and crying (Das et al., 2017). However, the mothers of children with ASD belonged to joint families that could have eased their psychological distress. In our study, mothers received support either or both from the child's father as well as the child's grandparents. The grandmothers had close relationship with mothers. It is not uncommon for grandmothers to be part of the caregiving process throughout the pregnancy and upbringing of child. This active participation is a welcome act in mothers' life, giving her the needed rest and time to look after other household chores (Baxter & Warren, 2016; Crettenden et al., 2018).

The mothers of children from both the groups also perceived adequate social support from family, friends and significant others. This realization could have mitigated the psychological distress (if any) arising among mothers of children with ID even in the absence of an extended family support.

Optimism is defined as a person's predisposition to anticipate favorable results in life (Conversano et al., 2010). Social support acts as an important mediator between optimism and psychological adjustment. A strong social support network can help mothers have a more positive attitude on life, which can lead to feelings of happiness. An individual's cognitive representations of the future may be altered as a result of feeling loved and supported. There is significant positive relationship between optimism, informal social support and maternal outcomes (Ekas et al., 2016). Thereby, it is not unforeseen that mothers of all children who reported higher levels of informal social support also reported lower levels of parental stress and higher levels of positive effect, life satisfaction and psychological well-being.

Limitations

The modest sample size can impact the generalization of the findings. The time bound nature of the course and its requirements were the limiting factors for its cross-sectional design. This study did not evaluate the effect of psychological and medical treatments, which are important determinants of psychological distress. The exclusion of fathers too could be seen as a shortcoming but the researchers observed that the mothers played the major caregiving role for children with special needs. Further research is needed to build upon knowledge on exploring the modern role of grandparents in needs of supporting care.

Conclusion

Despite its limitations, the study found that mothers of children with ASD and ID do not differ in their psychological distress. Their hardships and difficulties are buffered by adequate social support whether perceived or objective. The study also highlights the role of grandparents in the caregiving process. The findings can offer a glimmer of hope to the parents of children with special needs and divergence to the existing findings on psychological suffering in parents of children with ASD and ID.

Declarations

Funding: No funding resources

Conflict of interest: The authors declare that they have no conflict of interest

Code availability: Not Applicable

Ethical approval: Yes

Consent to participate: Yes

Consent for publication: Yes

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Harrington Essay Prize Winner: The eco-crisis and mental health of children and young people: Do child psychiatrists have a role?

Sheila Johnston

Introduction

The eco-crisis is a term increasingly being used to describe the effects of climate change on the Earth; changing weather patterns, global warming, changing biodiversity and the resultant effects on human and non-human populations [1]. During the 21st century there has been increasing recognition by professional organisations [2-5] that the eco-crisis can, and is affecting the mental health of children and young people. The level of concern expressed by young people about climate change and environmental effects has been brought to the general public's attention following the 'Fridays for Future' campaign spearheaded by Greta Thunberg.

However concern does not equate to mental illness, the diagnosis and treatment of which is the main role for child psychiatrists. The Royal College of Psychiatrists statement on mental health aspects of the eco-crisis [6], and associated podcast [7], suggests that for the majority of young people the worries expressed are normal experiences and not mental illness. Yet, by providing a statement and advice for young people and their parents/carers the implication is that psychiatrists do have a role to play.

Roles of the Child Psychiatrist in Response to the Eco-crisis

In order to understand what role(s) child psychiatrists can have it is important to understand the ways in which the eco-crisis and can affect children and young people. There is a burgeoning array of literature describing the effects on emotional wellbeing and mental health of the eco-crisis. The effects can be divided into three categories: direct effects, indirect effects and eco-distress [8,9]. The evidence also indicates that children and young people living in developing countries will be most affected [10]. This has implications for child psychiatrists, and mental health services in general. Service delivery will need to include not only local, regional and national planning but also global mental health initiatives. Child psychiatrists need to be involved in strategic planning of services.

The most recognised component of the eco-crisis is the direct effects: climate change and the environmental impacts that extreme weather events will produce e.g. flooding, extreme heat waves and forest fires. Such events are already recognised as being associated with Post Traumatic Stress Disorder (PTSD), depression, anxiety and sleep disorders [11]. The predicted increased frequency of such weather events is likely to increase the number of people experiencing the associated mental health problems. Heatwaves, and changes in body thermoregulation, can affect medication response resulting in illness relapse [12]. Exposure to repeated stressful events, including extreme weather conditions, in childhood can predispose to mental health problems in adulthood [10,13,14] and there is evidence that prenatal exposure to traumatic weather events increases the risk of the child developing disorders such as autism and schizophrenia [15]. The Royal College of Psychiatrist reports that 57% of child psychiatrists have seen patients who have expressed worry about climate change [6]. There are literature reports of these concerns worsening Obsessive Compulsive Disorder symptoms [16] and as a precipitant for delusional beliefs[17], furthering the psychiatric role of the child psychiatrist.

In all of these situations, child psychiatrists will have a role to play in diagnosis and treatment of mental health problems.

The indirect effects of climate change occur when there is damage or loss of the social and physical infrastructure e.g. displacement and migration, water or food shortage[8,9,18]. Hanigan et al report an increased risk of suicide in Australian farmers due to persistent drought, a consequence of climate change [19]. Parental loss, not only from suicide, is a recognised risk factor for development and attainment [20]. Child psychiatrists again have a role to play.

Migration is an inherent consequence of severe adverse weather events which have caused environmental and infrastructural damage. Migrants are often young adults and children. Risk of exploitation, financial stress, loss of identity and community, all associated with migration, increase the vulnerability to developing mental health problems. The United Nations University estimates there will be 200 million 'climate change migrants' by the year 2050 [21]. Child psychiatrists and mental health services, will have a role to play with migrants experiencing mental health conditions, as well as with migrant children who are brought into looked-after child settings. Child psychiatrists will be required to extend their knowledge of migration issues, increase their cultural awareness and sensitivity. Extended joint working practices with social services, interpretation services and legal/judicial services will be a necessity.

Climate change is predicted to affect marginalised communities leading to loss of culture, traditions and ways of life. Herscher, cited in Burke et al [10] reported increased depression and suicidal thinking in young people from indigenous Arctic communities due to polar ice loss and changing local habitats. Child psychiatry may be facing a significant rise in workload in order to manage children and young people at risk of completing suicide due to the adversities and concerns caused by the eco-crisis.

Local child psychiatry services will have knowledge of the local issues being influenced by the eco-crisis but may also be directly affected by them e.g. forest fires damaging community mental health facilities. Support needs to be available to psychiatric services that may be adversely affected, indicating the need for regional, national and global connections and planning amongst services [22].

The third category of mental health effects of the eco-crisis are what environmental philosopher Glenn Albrecht has termed 'psychoterratic syndromes' [23]. A number of new terms e.g. ecoanxiety, solastalgia and ecoparalysis have been coined to describe the concerns, anxiety and feelings of loss being experienced in response to climate change and concerns for future global effects of climate change[24-26]. Although these are in themselves not mental health disorders and can instead be considered as normal adaptive responses, there is a risk that a prolonged stress response will lead to anxiety and panic disorder, sleep disorder and health neuroticism[14,27]. Working with children and young people to use this normal adaptive response in a positive way offers opportunity for child psychiatrists to widen their remit. This will be further discussed later.

Research indicates that children and young people across developed and developing countries are worried by climate change[10]. In addition the indication is that children are more likely to accept the human contribution to climate change than adults, thus placing a burden of responsibility onto children[28]. The perceived lack of adult response was a component in the Fridays for Future campaign[29]. This then suggests there is a wider role for the child psychiatrist to become involved in, out-with their day-to-day ‘medical’ employment. There is the need to engage with young people to reach a shared narrative about the eco-crisis.

Described previously are examples of the impact that the eco-crisis is having on the mental health of children and young people, with examples of the role the psychiatrist plays. However, the wider role extends from professional duties to personal and social responsibilities.

Treatment options available to psychiatrists are not confined to medicines and talking therapies. There is evidence that nature-based activities are beneficial for everyone’s mental health[30,31]. Child psychiatrists have a responsibility to encourage ‘Green care’[32,33]. These activities have low environmental impact and are readily accessible to all. A walk in the local park has less impact on climate change than medication (manufacture, production and distribution of which all contribute to greenhouse gas emissions) and is cheaper than face to face therapies. Children and young people are by nature inquisitive and may benefit even more than adults from nature-based activities, particularly as such activities have a broad range of positive benefits including improved self confidence, self esteem and better communication[34,35]. By using and advocating for ‘green therapies’ the child psychiatrist has considered how their role may be contributing to the eco-crisis and what they in turn can do reduce ecological effects.

The child psychiatrist needs to have knowledge and understanding of the eco-crisis, the debates around climate change, global warming and environmental effects in order to have an open dialogue with patients and their carer, but also with their own family, friends and colleagues.

There is a responsibility to learn about the worries young people are experiencing and what problems are being brought not only to child psychiatry but other branches of medicine. Dialogue within families and social groups about the eco-crisis expands knowledge of the concerns being experienced within society. This knowledge can then be used in planning strategy for future service provision. Who and where will experience difficulties associated with the eco-crisis and which services should be prioritised. To further facilitate understanding, the child psychiatrist can become involved in research, perhaps on specific eco-crisis related mental health conditions or the eco-crisis as a public health concern[36-38]. Research in turn then offers opportunity for the child psychiatrist to influence and be involved in policy making. This could include decision making through local committees, the Royal College of Psychiatrists, General Medical Council or at government level.

For many young people the mental health effects of the eco-crisis are considered adaptive[7,27]. These young people may not come to the attention of mental health services, however as doctors, psychiatrists have a responsibility to 'protect and promote the health of patients and the public' and be honest with patients. The eco-crisis is a public health issue which doctors need to be involved with [11,22,36]. Working with young people can be used to take forward their ideas to meetings and committees which young people may not have access to. Young people can be encouraged, motivated and given opportunity to bring forward their views, opinions and ideas. Promoting positive action by young people potentially reduces the risk of an adaptive response becoming maladaptive or considered ill health. Promoting resiliency in young people is not just the role of the psychiatrist but also the psychiatrist's role as an adult.

The UK Health Alliance on Climate Change [39] (of which the Royal College of Psychiatrists is a member) and the American Psychological Association [40]are example of medical associations which have produced guidance on the different ways mental health professionals can involve themselves in attempting to reduce the impacts of climate change, for example recycling in our own household, advocating for renewable resources in our workplace and engaging with the wider community to develop and support greener solutions through volunteering or lobbying. "A systems approach complemented by a new style of research thinking and leadership, can help align the needs of this emerging field with existing and research policy agendas" [41]. Child psychiatrists, who utilise systemic thinking in every day practice, would therefore seem to be in the ideal position to play a significant role in research and planning. Educating the future generation of child psychiatrists [42] by including 'green psychiatry' in training will ensure eco-crisis concerns and the need for action is at the forefront of psychiatric practice.

For the child psychiatrist becoming involved in such activities will be for the greater good of all. It brings the potential to benefit the mental health of all young people, not just those with mental health disorders.

Conclusion

There is acceptance that the eco-crisis is real and is having effects on the mental health of children and young people. Some effects can be deemed positive and the child psychiatrist can help the young person use this as a means of helping to reduce the effects of the eco-crisis. However there is the more worrying aspect of the detrimental effects of the eco-crisis on children and young people. As described the child psychiatrist has many roles to play; psychiatrist, adult, learner, teacher, parent, relative, global citizen, researcher, service planner, policy influencer, volunteer, recycler, advocate for reducing of our own carbon footprint. By involving themselves in all of these roles the child psychiatrist can potentially help reduce the number of young people who will experience serious mental health problems due to the eco-crisis and will also be helping to reduce their own impact on the eco-crisis.

In answer to the question 'the eco-crisis and mental health of children and young people: Do child psychiatrists have a role?' The answer is most definitely yes.

"To have done nothing is the ultimate child abuse."

Lise van Susteran

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Medical Student Essay Prize: COVID-19: The Great Revealer

Zunaira Dara

“In these times of significant social change, how can issues such as deprivation and poverty, and inequalities (inc. ethnicity) affect the mental health of children and young people”

Child and adolescent mental health in the era of COVID-19:

Child health in the UK was at a crisis point even before the COVID-19 pandemic hit, with 4.3 million children living in poverty just a year prior to the first case of SARS-CoV-2. [1] Perhaps even starker are the 2019-20 figures for child poverty among ethnic minority groups: 46% of all black, Asian and minority ethnic (BAME) children live in poverty, compared to 26% of white British children.[1]

The National Children’s Bureau’s 2015 ‘*Poor Beginnings’* report states that “simply by growing up in a certain part of England, a child under 5 is more likely to have poor health that will impact the rest of their lives”.[2]

It is no surprise, then, that COVID-19 has disproportionately impacted children and families from BAME and/or lower socioeconomic backgrounds: rather than a “great equalizer”,[3] the pandemic has proved to be a “great revealer”, highlighting the health inequity[1] and social injustices embedded in British society.

Since the introduction of COVID-19 restrictions on 23rd March 2020, there has been a sharp rise in the incidence of mental health issues among children (aged 5-16) and young people (aged 17-22).

One in ten children and young people (CYP) reported that they often or always felt lonely; more than 25% struggled with disrupted sleep.[4] Many children have also reported feeling anxious about catching COVID-19, with 18% feeling fearful of leaving the house.[4] Unsurprisingly, the pandemic has also increased the incidence of mental health issues among parents, which has a knock-on effect on child mental health.[4]

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[1] Health inequality refers to the “uneven distribution of health resources” whereas health inequity is defined as “avoidable differences arising from poor governance, corruption or cultural exclusion”. [44]

The anxiety around COVID-19 has led to a significant drop in the number of people accessing healthcare, with 44.6% of young people who struggle with mental health issues not seeking support due to the pandemic.[4]

Restrictions around meeting family and friends, as well as school closures, have meant that there is an increasing number of cases of abuse, mental health problems and other developmental issues that go unnoticed. Due to the lack of timely intervention, we can expect an exacerbation of pre-existing health and educational inequalities which will have long-lasting repercussions.

Far from being a so-called “great equalizer”,[3] the pandemic has hit those living in poverty the hardest. With many businesses closing due to lockdown and people being made redundant, there has been greater demand for universal credit, which was increased by only £20 a week to cover extra expenses during lockdown. Rates of food poverty have also increased, with families who would normally rely on free school meals being forced to turn to food banks and other emergency measures during school closures.[5]

Physical health is linked to mental health:

We cannot discuss the disproportionate effect COVID-19 has had on the mental health of young people without first acknowledging the disparities in physical health, because they are inextricably linked; poor physical health increases the risk of poor mental health,[6] specifically depression and anxiety. Conversely, poor mental health can exacerbate physical illness – costing the NHS £8 billion a year.[6]

It is a well-established fact that poverty, race, ethnicity and social marginalisation are important determinants of physical health.[7, 8]

Throughout history, epidemics and pandemics such as influenza, Ebola, tuberculosis and malaria have had a disproportionate effect on the most marginalised in society.

We have seen the same pattern with COVID-19, with 26% of intensive care admissions due to COVID-19 being patients from BAME backgrounds despite BAME people only making up 14% of the UK population.[9,10]

COVID-19 mortality rates are 3.5 times higher among the BAME population when compared to rates in the white British population, with the highest mortality among people living in the more deprived areas.[11]

Poverty is associated with poor health at all stages of life. Infants born in the most deprived areas have on average a birth weight that is 200g lower than infants born in the richest families,[12] and low birth weight is associated with developmental problems and poorer health in later life. There is also a link between poverty and infant mortality, with children living in deprived areas being more than twice as likely to die in the first year of life compared to the least deprived areas.[13] Shamefully, the infant mortality rate in the UK has been rising since 2018 and is shockingly high in the most deprived areas, at 5 per 1000 live births.[13]

Children growing up in deprivation are more likely to suffer from diet-related health problems, including obesity, as well as chronic diseases.[12] Poverty also impacts cognitive development; studies report reduced grey matter in the frontal and temporal cortex as well as hippocampus, impacting children's school readiness and achievement.[14]

Poverty also impacts mental health, with children living in poverty being over 3 times more likely to suffer with mental health issues.[15]

In addition to this, the poor physical and mental health of caregivers negatively impacts children: it takes away from quality of time spent with parents, adds financial insecurity, and can force children to take on the responsibilities of being a young carer. Reduced self-efficacy in parents due to physical or mental health issues has been associated with more disruptive behaviour in children.[16] This is likely a result of repeated instances of separation from the primary caregiver due to hospital admissions and reduced capacity for parent to form a healthy attachment with the child, causing emotional trauma, as outlined by attachment theory.[17,18] Children are more likely to cope well with parental illness if health problems are short-lived and not recurring, and parents are able to communicate to children what is happening and why.[17]

Since the onset of the pandemic, most efforts have been focused on protecting the most medically vulnerable to the virus, but little to no attention has been paid to those vulnerable to the complications of COVID-19 due to social determinants of health.[19]

Evidence suggests that social determinants play a bigger role in determining health status than lifestyle choices and access to healthcare[8]: as medical professionals, we cannot hope to improve the health of our patients by ignoring the social inequities that bring about and exacerbate disease.

The effects of health inequity on child and adolescent mental health:

The Department of Health and Social Care's 2011 policy paper titled "*The Mental Health Strategy for England*" defined mental wellbeing as "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment".[20]

According to Maslow's hierarchy of needs (Figure 1), in order for a child to develop well, reach their full potential and achieve mental wellbeing, their most basic needs must first be fulfilled.

Child and adolescent mental health is currently at a crisis point. State fragility, food insecurity, social restrictions and access to health services all play a role – but these issues do not affect all children equally.

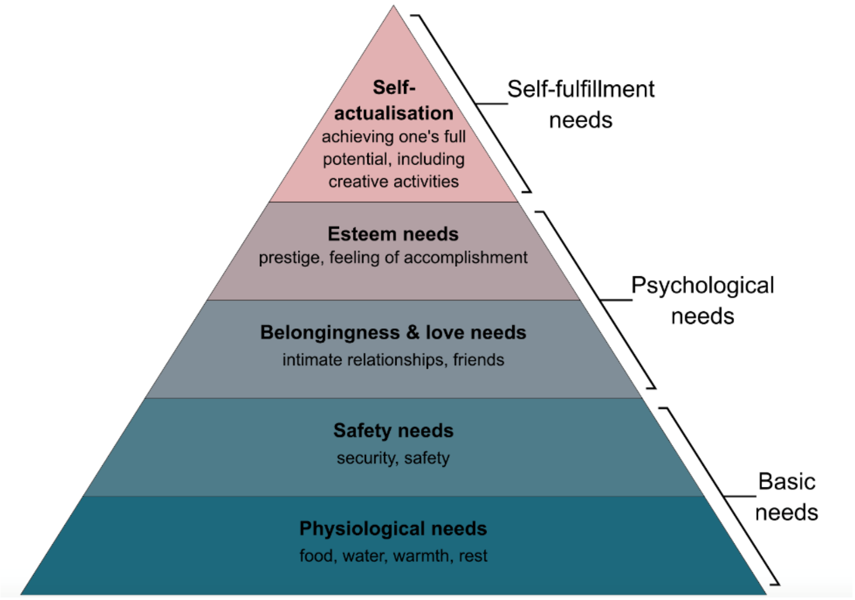

Figure 1: Maslow's hierarchy of needs. Basic needs, i.e. physiological and safety needs, must be satisfied before those higher up in the hierarchy can be satisfied [21]

The UK Millennium Cohort Study (MCS), a longitudinal study of 9818 children, has so far followed up children and their families at 9 months, 5, 7, 11 and 17 years of age. The study uses self-reporting methods to measure participants' socio-emotional, physical, cognitive and behavioural development over time, alongside information relating to socio-economic circumstances, family life and parenting.

Findings from the study suggest that 1 in 10 children suffer with socioemotional behavioural problems by age 11, and that this number was much higher in children from disadvantaged backgrounds.[22]

Factors influencing this difference in outcomes included poverty, maternal mental health and bullying.[22]

The following section will explore factors contributing to inequalities in CYP's mental health by highlighting a clinical case that embodies the impact of health inequity.

Clinical case study:

The following case study will illustrate the impact poverty and being from one of the most marginalized ethnic groups has had on the life and mental health of a young girl, patient X.

Patient X is of Roma background, one of the most marginalized ethnic groups in the UK. According to a 2019 report by the House of Commons Women and Equalities committee, children from Roma, Gypsy and Traveller backgrounds had the lowest school attainment of all ethnic groups.[23]

The report also states that life expectancy amongst this group is 10-12 years less than that of the general population, with 42% of the community being affected by a chronic health condition compared to 18% of the general population.[23]

Child mortality is also higher in this population, with 1 in 5 Roma, Gypsy and Traveller mothers losing a child before the age of 5, compared to 1 in 100 in the general population.[23]

Roma, Gypsy and Traveller people are also less likely to report being satisfied with access to a GP as well as the service they receive.[23]

Patient X is an 11-year-old female who presented to hospital, accompanied by her mother, with a BMI of 48 kg/m^2.

All efforts to encourage reduction of the patient's weight in the community had been exhausted by medical professionals; this included family education about diet and exercise.

Being obese was affecting patient X's psychological and physical well-being. She became tired and breathless quite quickly with exercise. This prevented her from being able to join in school and social activities, which inevitably affected her self-confidence.

She was admitted to hospital for a period of 10 days to investigate concerns that the family were not following medical advice and were, in turn, endangering her health, a form of neglect and a safeguarding issue.

On admission, the patient had a blood pressure of 150/100 mmHg, was diagnosed with hypertension and started on treatment with amlodipine to reduce her blood pressure and orlistat to aid weight loss. During her time in hospital, the patient was on a normal diet but advised not to snack. She was also encouraged to stay active by walking, running and hula hooping. The patient was able to lose 2.1kg during her admission. Professionals noted an improvement in the patient's self-confidence and she reported that she felt proud of herself.

There was some tension reported between the nursing staff and the patient's mother, as she refused to stop bringing the patient snacks, especially chocolate. The mother was also resistant to physical exercise, and interrupted sessions when she saw the patient was slightly out of breath or struggling.

It is possible that the friction between patient X's mother and medical professionals stemmed from a general mistrust of healthcare providers, which delayed their access to care until patient X was morbidly obese. It also meant the mother was less likely to implement lifestyle changes for the family in a manner concordant with medical advice and became an obstacle to her daughter's weight loss during her hospital stay.

The strained relationship between patient X's family and healthcare professionals came to a head when patient X started to re-gain weight when discharged from hospital (see Figure 2). Professionals sought a court order to have patient X removed from her parental home and placed in foster care where patient X is now thriving and has continued to maintain her weight loss.

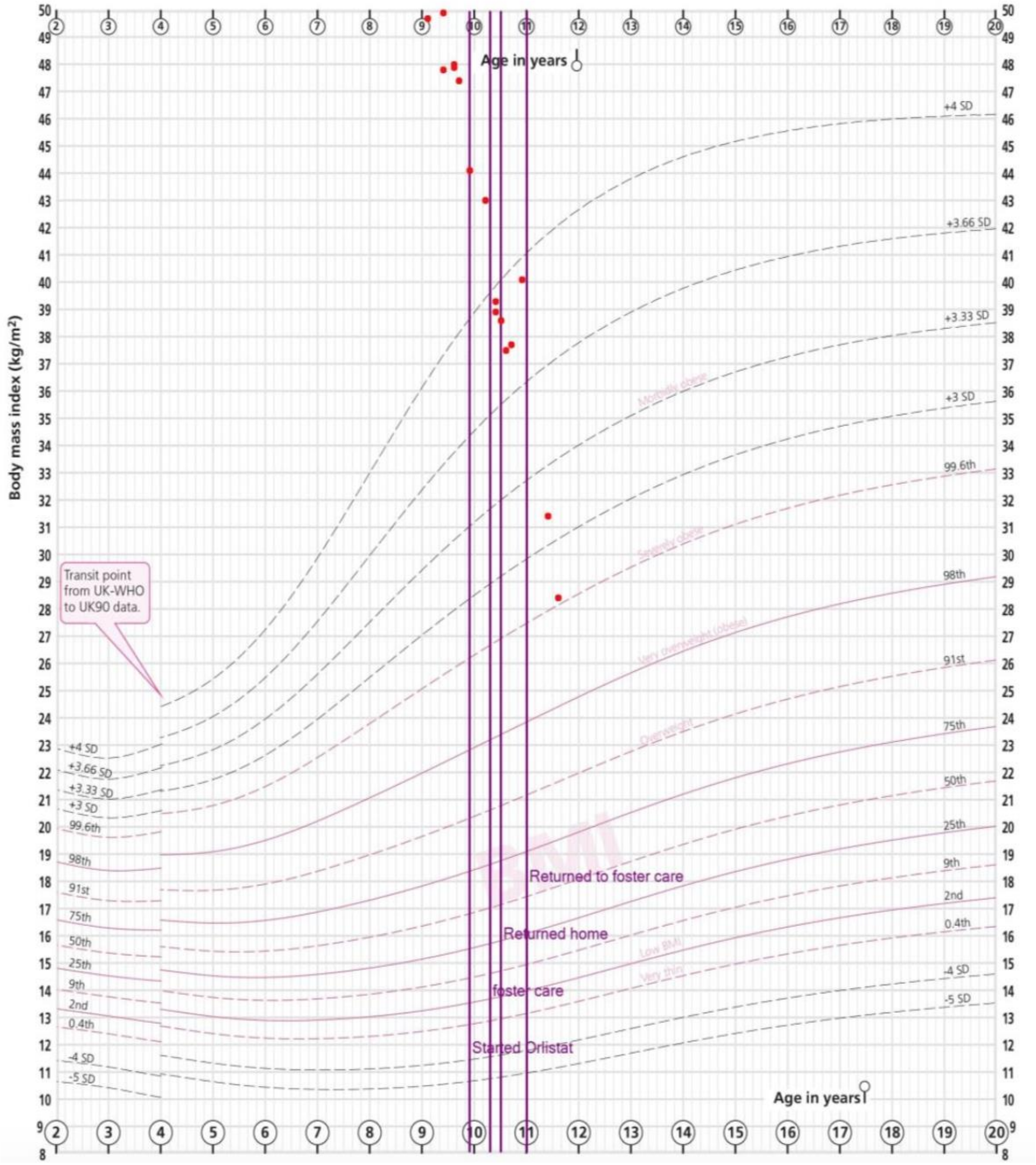

Figure 2: BMI of patient X over time. Weight loss when started on Orlistat in hospital, maintenance of weight loss when placed in foster care, rapid increase in weight when returned home followed by a sharp decline in weight, which is maintained, when returned to foster care. Figure reproduced with permission from lead clinician.

Patient X is now off all medications and her most recent blood pressure reading was 129/85 mmHg with a BMI of 31.5 kg/m^2.

Being placed into foster care has benefitted patient X by improving her physical health and her psychological well-being as she has been reported to be doing well in school, maintaining a healthy diet and enjoying exercise as well as improving her self-confidence.

It is undeniable, though, that the experience of being removed from one's family is a profoundly traumatic one. Medical professionals involved in patient X's care have reported that the event has affected her psychologically and that she misses her family. Such a traumatic experience will no doubt impact patient X mentally and emotionally well into adulthood, making her vulnerable to mental health issues in later life.

Food poverty:

Another aspect that could affect patient X's mental health in the long term is the fact that she has grown up in poverty.

As Figure 3 illustrates, children living in financially unstable households were more than twice as likely to suffer with mental health problems compared with those whose families were able to pay their bills.[24]

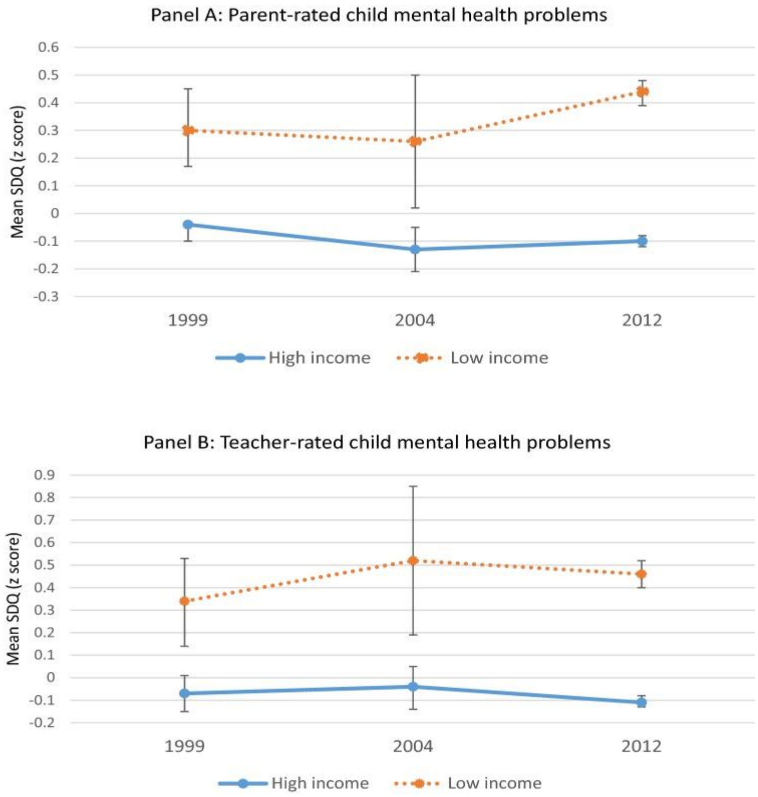

Figure 3: Differences in childhood mental health based on household income[25]

Food insecurity is on the rise, with 1 in 10 CYP reporting their family did not have enough food to eat or had to rely on food banks.[24] Family poverty has been identified as having causal effects on child mental health, but spending cuts by the UK government over the last 10 years have impacted household incomes, financial security, as well as health programmes and mental health services: the most disadvantaged are worse off in terms of income, but they also cannot access the mental health support they now need more than ever.[25] Tudor Hart identified the need for the state to ensure the well-being of groups excluded by social and market forces when he detailed the inverse care law in 1971,[26] but we continue to see the marginalisation of the most vulnerable and the perpetuation of health inequalities.

There is an independent relationship between childhood hunger and poor school attainment, reduced immune function and physical growth and increased incidence of chronic illness.[27] Hunger has been identified as causing psychological distress and contributing to toxic stress. Toxic stress is defined as activation of the body's stress response that is strong, frequent and prolonged in nature; it is associated with stunted development and adverse health outcomes.[28]

Many studies have found that food insecurity plays an independent role in increasing risk of mental illness.[29] Physiological changes reduce children's ability to cope with stress; unpredictability of meal times and food availability contribute to anxiety; inability to provide sufficient food for children results in maternal distress, which has a direct effect on children's emotional wellbeing.[27] Social isolation and stressful life events further compound the risk of mental illness.[29]

Education:

Poverty also affects school attainment, and children from poorer families have been doubly disadvantaged during the pandemic. Participation in online lessons was hampered by factors such as having no access to reliable internet access, which affected 12% of pupils.[24] 19% of children reported having no quiet space to work, and 26.9% of children did not have a desk at which they could study.[24]

Many disadvantaged families only had access to one device, so they struggled to find a balance between home-schooling and working from home, contributing to stress and resulting in missed lessons for children.[24] Many teachers have raised concerns over the loss of learning experienced by students from low-income families, and those of BAME and Traveller backgrounds.[30]

The loss of school time during the pandemic is estimated to equate to a loss of £40,000 in income over a child's lifetime [31]: this amounts to a £350 billion loss in lifetime earnings across the UK's 8.7 million school-aged children.[31]

Negative effects of school closure are 50% larger for children from disadvantaged backgrounds, resulting in widening inequalities,[31] and perpetuating heath inequity for patient X and children like her.

Lack of green space:

Outdoor play is essential during childhood: it improves physical and mental health, including lowering the risk of obesity. Growing up in deprived areas means children like patient X do not have adequate access to open and green space.

Studies have found that green space is associated with improved neurodevelopment and cognitive skills, as well as improved social, emotional and behavioural development.[32]

One study found that more than 60% of CYP in London did not have adequate access to open and green space at their schools, where they spent between 35-40 hours a week.[33] They also found that children from wealthier families were more likely to participate in a wide range of out of school activities that mitigated the lack of green space at school, when compared to children on free school meals.[32]

Living in a deprived area with a lack of green spaces is yet another factor that is not within the control of patient X or her family, but which has nonetheless negatively impacted her childhood, and possibly her adulthood.

Physiological effects of toxic stress:

As mentioned above, toxic stress is characterised by the prolonged activation of the stress response and a failure of the body to recover fully.[33]

Toxic stress results in immune dysregulation and a persistent inflammatory state, increasing the risk and frequency of infections as well as increasing the risk of metabolic disorders and cancer.[33] It is also believed to play a role in the pathophysiology of mental illness.[33]

Recent studies have found an association between toxic stress and modifications to the genome, known as epigenetics.[34]

Epigenetics is the study of modifications to the genome that alter how certain genes are expressed; it is believed that these modifications occur in response to environmental stressors. Studies on the effect of childhood adversity on epigenetics have found that trauma during childhood or adverse childhood events (ACEs), including poverty, abuse, racism, discrimination and differential treatment, was associated with higher levels of methylation of the NR3C1 gene which encodes a glucocorticoid receptor (GR).[35]

The GR is a receptor involved in the hypothalamic-pituitary-adrenal (HPA) axis, the central stress response system. GR binds to cortisol (the stress hormone) and it is involved in development, metabolism and the immune response. Studies showed that childhood adversity modified responsiveness of the HPA axis, leading to alterations in affective and behavioural phenotypes,[35] essentially reducing the individual’s ability to cope with stress. One drawback of these studies was that it was impossible to eliminate confounding factors such as parenting style and personality type.[35]

These epigenetic changes can determine the path a child’s life will take. Although some studies have found that environmental enrichment can alleviate some of the adverse outcomes of early childhood stress,[36] without intervention, these changes increase the risk of developing heart, lung and liver disease, cancer, obesity, GI disorders, autoimmune conditions, chronic pain disorders as well as mental health conditions such as depression, anxiety, PTSD and suicidality in later life.[35] In fact, one study found that adults with ACEs died nearly 20 years earlier than those with no history of ACEs.[37] Children who have faced adversity in childhood are also more likely to smoke, struggle with substance abuse and display other behavioural issues.

Research has also determined that maternal environmental stressors can cause epigenetic modifications in utero, and that these changes are predictors for disease in later life.[38] Maternal poverty, poor maternal diet, domestic violence, maternal illness and harmful behaviours such as smoking and substance abuse have all been associated with epigenetic modifications that predispose the fetus to chronic conditions in later life.[39,40]

Data from the emerging field of epigenomics suggests that children from lower socioeconomic status and BAME backgrounds are burdened with the impact of systemic racism and health inequity from the moment of conception - and, according to theories around transgenerational epigenetic inheritance, maybe even before that.[41] If this is the case, we may see the consequences of the worsening health of marginalised groups during the pandemic for generations to come.

Race and health:

The year 2020 brought about a series of events, from the dawn of the COVID-19 pandemic to the murder of George Floyd, that led to a racial awakening. This, in turn, has led mainstream media to start focusing more on the injustices in our society; under this renewed spotlight, health inequity has become a much-discussed topic.

The concept of race-based health inequality is not a new one. Jim Rose's "*Colour and Citizenship*", published in 1969, focused attention on racial inequity in Britain and detailed how political policies and practice not only failed to address racial inequalities but also gave rise to them.[42]

Rose identified, more than 50 years ago, that the inequalities faced by people of colour were not 'satisfactorily explained in terms of class or… strangeness': he found that race had an independent and enduring effect.[42]

Despite the National Health Service's long-standing commitment to tackling inequalities, from legal framework (Race Relations Act 1965 to the Equalities Act of 2010) and policy directives to special initiatives aiming to protect marginalized groups from unfair treatment, the reality is that inequitable access, experiences and outcomes of care continue to be reported.[43] A 2016 study of senior decision-makers within the NHS found that obstacles to racial equity included marginalisation, with issues affecting ethnic minorities being treated as less important and being allocated fewer resources; ambivalence among senior leaders, with some policy-makers being unconvinced of the reality of racial inequities; and a lack of clarity and confidence amongst staff on how inequity should be addressed.[43]

Inevitably, these ambivalent attitudes show up in how the NHS treats patients of BAME backgrounds and even BAME people in its own workforce [2].

In order to reduce the burden of health inequity, healthcare professionals must be willing to challenge their own biases and beliefs. There is a need for strong leadership that is representative of and voices the concerns of the most marginalised and a revamp of policy is needed to focus resources on the population of disadvantaged children who are likely to suffer the most in the post-COVID world.

The COVID-19 pandemic has created a sense of insecurity, making the UK feel like a fragile state for the poorest and most marginalised individuals. COVID-19 has not affected everyone equally because of the historical failures in addressing inequities in healthcare and government policy.

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[2] Enoch Powell's 'rivers of blood' speech in which he demonized migrants, took place only 5 years after he had campaigned to recruit 18,000 migrant doctors to fill staff shortages in the NHS [12,13]

The UK has been unable to fulfil the most basic needs (see figure 1) of the most vulnerable children and we will inevitably see the repercussions of this in the coming years with a rise in mental health conditions and social and behavioural problems.

Poverty, deprivation and ethnicity are undeniably powerful influencers of childhood development and mental health, mapping out the path a child's life will take and even determining their health in later life.

In order to mitigate the effects of COVID-19, health policy for the recovery phase must make child and adolescent mental health a priority. We cannot afford to overlook this aspect of public health because the future of our nation relies on the health and wellbeing of our children.

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Opportunity to join a CAMHS TPD Network

Meinou Simmonst

Having been appointed CAMHS TPD for Thames Valley this year, I am keen to re-start a national CAMHS TPD network. I heard from my predecessor that this had been in place a few years ago and had been facilitated through the college. I think it would be great if we could set this up again with current CAMHS TPDs as we could learn a lot from each other. I would like to set up an initial digital meeting in the new year and have already heard from some of the regional TPDs through a college call, but we may not have reached all the TPDs yet. If you are a TPD and would like to be included and haven’t yet responded, please email me on Meinou.simmons@oxfordhealth.nhs.uk.

Dr Meinou Simmonst

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Surviving fifty years with Shrapnel within the brain

Muhammad Sayad Inam

Abstract

Introduction: Traumatic brain injury during the war by shrapnel or bullet is lethal and life-threatening. The mortality rate from traumatic brain injury is more than 90%. Mrs. N (70) of Bangladesh is an exceptional and one of the luckiest women of the world in the 21st Century. She is a war victim and has been living with shrapnel within her brain for the last 50 years.

Case history:

On April 28, 1971, during the liberation war of Bangladesh, the opposition military force launched several mortar shell attacks on Mrs. N's village and one of the shells exploded in their backyard. A few of Mrs. N's family members were died on the spot, while she was seriously injured. At that time, a piece of shrapnel penetrated her body and head. She lose her consciousness and was later treated nearby the war hospital as best as possible. Mrs. N Begum is now 70 years old, is still carrying those fragments of violence unleashed within her skull.

Last 50 years, shrapnel continued to travel through the deeper structures of her brain. It created a big cyst within the brain. This is called Encephaloclastic Porencephaly.

She has been living with several neurological and psychiatric complications for the last fifty years. She has weakness in the left upper and lower limbs, forgetfulness, headache, dizziness, occasionally disorientation, convulsions, occasionally hearing of unknown voices, fearfulness, and cognitive deficit. As her condition worsened, her family members took her to my private chamber for treatment.

Mrs. N and her family members were unaware of the head injury. Even they have no medical documents about that past pathetic incident.

Considering her traumatic blast injury history, an X-ray skull was advised. Surprisingly, it showed a piece of shrapnel lodged within her skull! Furthermore, to confirm the shrapnel, and other depth of injury, she was advised to have an urgent CT scan of the brain. The CT showed shrapnel within her brain created a big encephaloclastic cyst. Cyst occupies her entire right parietal and frontal lobes. Shrapnel gradually affected the functioning of her brain for the last 50 years.

To control her psychotic symptoms, Risperidone 2mg and other supportive medication were advised. She was also referred to a Neurosurgeon of the National Institute of Neuroscience for further management. After through General and systemic examination, the Board of Neurosurgeons decided to remove the shrapnel, but Mrs. N and her family denied it.

Discussion: The discovery of unsuspected intra-cerebral shrapnel or bullet years after the injury has rarely been reported. Shrapnel within the brain for a long time creates encephaloclastic porencephaly [1]. The location of Penetrating cerebral wounds is varied from study to study. The main locations were frontal, parietal, or temporal [2] [3]. The seriousness of injuries depends on several factors. These are GCS score, their extension, location, cerebral injuries, and management [4]. GCS score is very important. A lower GCS score predicts a poor outcome and a higher one a better outcome [5],[7],[6].

Other factors, associated with a poor outcome, are multi-lobar injuries; interventricular hemorrhage, and dominant hemispheric injuries [5], [6], [7], [8]. After recovery from the preliminary injury, most patients are asymptomatic [9]. The shrapnel gradually becomes encased in fibrous tissue and is considered inert [10]. Rarely, however, shrapnel causes harm in the long term, either in the form of systemic damage because of shrapnel degradation or because of a local foreign body reaction. Lead shrapnel retained in soft tissue can cause plumbism [11]. Shrapnel wounds should be treated on a case-by-case basis. The four C's of muscle viability; color, consistency, capacity to bleed, and contractility are used to assess. In the acute phase, lifesaving procedures are performed to hemodynamically stabilize the patient [12]. Retained fragments are usually benign, and the surgeon should not attempt to remove them [13], [14]. Conclusion: Delayed recognition of cerebral foreign bodies is very rare. In this case, the longest time of shrapnel within the human brain accompanied by psychotic symptoms is presented and discussed. Surviving 50 years with shrapnel within the brain is the rarest condition in medical science.

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ADHD medications prescribing in CAMHS LD team, Leicestershire

Ayat Ali

Zehra Jafar

Background:

ADHD (Attention Deficit Hyperactivity Disorder) is one of the most prevalent neurodevelopment disorders in childhood affecting 5% globally [1] and is thought to affect about 1 in 20 children in the UK. ADHD medication is commonly prescribed in CAMHS with many children on second or third line of treatment as well as some on combination. These prescriptions, however, may not have been made in adherence to the best practice recommended by NICE. In this audit we looked at ADHD medication prescribing in the CAMHS LD (Child and adolescent Menal Health Learning Disability) team in Leicestershire.

Aim:

Improve mental and physical health outcomes for LD patients in CAMHS prescribed medication for ADHD

Objectives:

- Review prescriptions of ADHD medications to establish prevalence and possible reasons for prescription that doesn't adhere to NICE standards
- Review if patients on ADHD medications have at least annual reviews of their medications

Table 1: criteria

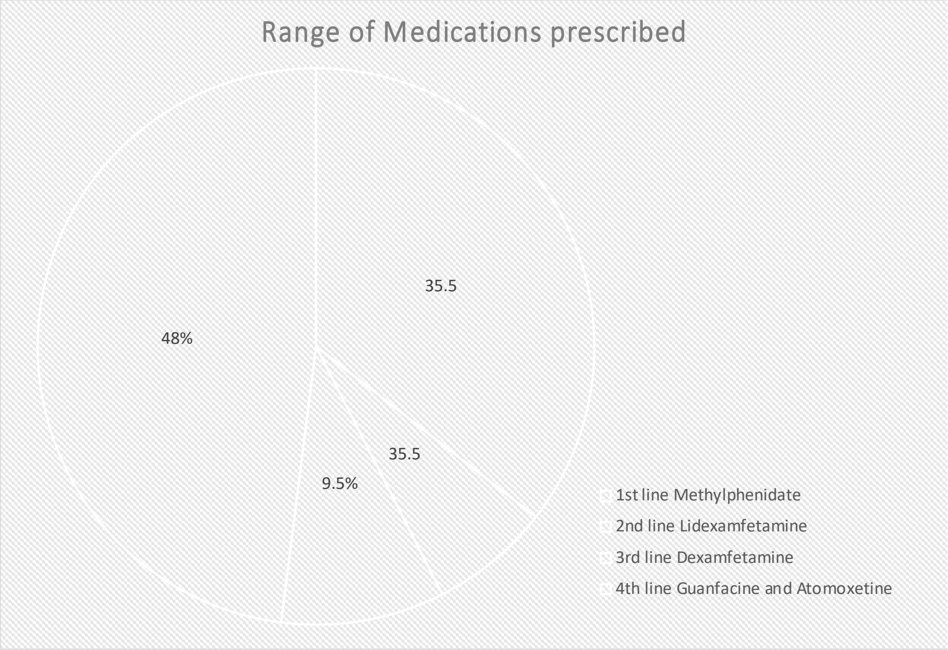
	Criteria	Standard	Full compliance >= %	Partial compliance >= %
1	1.7.7 Offer methylphenidate (either short or long acting) as the first line pharmacological treatment for children aged 5 years and over and young people with ADHD.	100%	90%	80%
2	1.7.8 Consider switching to lisdexamfetamine for children aged 5 years and over and young people who have had a 6-week trial of Methylphenidate at an adequate dose and not derived enough benefit in terms of reduced ADHD symptoms and associated impairment.	100%	90%	80%
3	1.7.9 Consider dexamfetamine for children aged 5 years and over and young people whose ADHD symptoms are responding to lisdexamfetamine but who cannot tolerate the longer effect profile.	100%	90%	80%
4	1.7.10 Offer atomoxetine or guanfacine to children aged 5 years and over and young people if: • They cannot tolerate methylphenidate or lisdexamfetamine or •Their symptoms have not responded to separate 6-week trials of lisdexamfetamine and methylphenidate, having considered alternative preparations and adequate doses.	100%	90%	80%
5	1.10 Review of medication and discontinuation A healthcare professional with training and expertise in managing ADHD should review ADHD medication at least once a year and discuss with the person with ADHD (and their families and carers as appropriate) whether medication should be continued. The review should include a comprehensive assessment of the: ☐ preference of the child, young person or adult with ADHD (and their family or carers as appropriate) ☐ benefits, including how well the current treatment is working throughout the day ☐ adverse effects ☐ clinical need and whether medication has been optimised ☐ impact on education and employment ☐ effects of missed doses, planned dose reductions and periods of no treatment ☐ effect of medication on existing or new mental health, physical health or neurodevelopmental conditions ☐ need for support and type of support if medication has been optimised but ADHD symptoms continue to cause a significant impairment. (for example, psychological, educational, social)	100%	90%	80%

Methodology:

A randomised sample of cases was extracted from a list of all patients under the CAMHS LD service (July 2021). These were reviewed against an agreed clinical audit toll hosted on AMAT, based on medication standards from NICE NG 87. Population was approximately 80 (active patients on ADHD medications) and audit sample size was 42.

Results:

Figure 1:



35% were on first line ADHD medications

Second and third line:

- All patients on Lisdexamfetamine (n=3) had a trial of Methylphenidate
- None of patients (n=4) on Dexamfetamine had a trial of Lisdexamfetamine or Methylphenidate
  - ➢ Rationale wasn't clear

Fourth line (Atomoxetine and Guanfacine)

- 48% of total sample
- 24% (10) on Guanfacine and 24% on Atomoxetine
- 60% were prescribed according to NICE guidelines
  - In 17% of patient could not tolerate 1st line Methylphenidate or 2nd line Lisdexamfetamine
  - In 12% symptoms had not responded separate 6-week trials of 2nd line Lisdexamfetamine and 1st line Methylphenidate, having considered alternative preparations and adequate doses
- In 40% of cases 4th line was prescribed for reasons not expressly approved by NICE. These were:
  - The patient's inability to tolerate tablets 40%)
  - "Patient was concerned about side effects on appetite and weight loss"
  - "Concerns about short acting effect"
  - "Anxiety alleviating effects of Atomoxetine and Guanfacine"

- “Parents worried about Methylphenidate wearing-off after school”
- Anxiety about possible “rebound effect” of stimulants
-

Combination of medication:

- 5% combined Methylphenidate with Atomoxetine, for the “Longer acting” effect
- 2% combined Methylphenidate with Lisdexamfetamine, because there was no enough effect from Methylphenidate
- 2% combined Methylphenidate with Guanfacine, to help with “anxiety”
- 2% combined Lisdexamphetamine and Dexamfetamine, for added “immediate release effect” in the evening
- 2% combined Atomoxetine then added Dexamfetamine, for an “added longer acting effect”

Table 2:

5. Medication has been reviewed at least annually by a healthcare professional with training and expertise in managing ADHD		36	42	86%
5.1. It is recorded that discontinuation/continuation was discussed		33	36	**92%**
5.2. It would have been appropriate to involve family / carer/s in review		36	42	**86%**
5.2.1. It was recorded that family / carer/s were involved in annual medication review		36	36	**100%**
The record of the review included a comprehensive assessment of:	5.3. The preference of the child, young person with ADHD (and their family or carers as appropriate)	35	36	**97%**
	5.4. therapeutic benefits, including how well the current treatment is working throughout the day	35	36	**97%**
	5.5. Adverse effects	34	36	**94%**
	5.6. Clinical need and whether medication has been optimised	36	36	**100%**
	5.7. Impact on education (and/or employment if applicable)	30	36	**83%**
	5.8. Effects of missed doses	28	36	**78%**
	5.9. Effects of planned dose reductions	24	36	**67%**
	5.10. Effects of periods of no treatment	30	36	**83%**
	5.11. Effects of medication on existing or new mental health, physical health or neurodevelopmental conditions	33	36	**92%**
	5.12. The need for support and type of support if medication has been optimised but ADHD symptoms continue to cause a significant impairment (for example, psychological, educational, social)	32	36	**89%**

Discussion:

Almost half of patients (48%) were on 4th line. Of these, only half of them tried stimulants first. 92% of patients, where first line wasn’t not prescribed, had rationale recorded. However, in 40% , rational was mainly about prescribing a medication that has a liquid formulation. It is acknowledged that children who present to CAMHS LD often has complex presentations and sensory sensitivities. It is important to consider, however, if unavailability of liquid form in the first line medications is having a crucial impact on having an effective treatment of their ADHD.

Overall, there was good level of compliance with annual review but and only 67% reviews discussed effects of planned dose reduction. Reasons for this will need to be explored further and multiple factors will influence decision on dose reduction, nonetheless, medication reviews should include dose reduction discussion, especially on the annual reviews.

Conclusion and next steps:

Further exploration is needed into the underlying causes of not meeting standards in following NICE guidelines with regard to trying first line medications for ADHD before other medications. Whilst 40% of rationales of prescribing 4th line medications aren’t necessarily in line with NICE guidelines, they do appear to represent decision made with good clinical intentions and in 86% of cases it was done with patient involvement or input.

The results will be taken to the multidisciplinary team to discuss and reflect on the results, specially with regard to the impact of unavailability of liquid formulation in first line medications on patient’s choice of medications.

References

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

Qualitative review of initial Self-Harm assessments within CAMHS

Khushbu Zia, M Thomas & S Shaefer

Introduction:

The significance of mental health has never been greater in light of recent events involving the impact of covid-19 but more so in children and younger adults, it’s had a serious influence. According to Youngminds.org.uk, One in six children aged five to 16 were identified as having a probable mental health problem in July 2020, a huge increase from one in nine in 2017. That’s five children in every classroom (i)

The number of A&E attendances by young people aged 18 or under with a recorded diagnosis of a psychiatric condition more than tripled between 2010 and 2018-19 (ii).

80% of young people with mental health needs agreed that the coronavirus pandemic had made their mental health worse (iii).

In 2018-19, 24% of 17-year-olds reported having self-harmed in the previous year, and seven per cent reported having self-harmed with suicidal intent at some point in their lives. 16% reported high levels of psychological distress (iv).

Suicide was the leading cause of death for males and females aged between five to 34 in 2019 (v).

Nearly half of 17–19-year-olds with a diagnosable mental health disorder has self-harmed or attempted suicide at some point, rising to 52.7% for young women (vi).

Objectives:

As Self harm is a common presentation within the CAMHS speciality, we decided to evaluate the initial self-harm assessments conducted in the local CAMHS setting.

A Full assessment is mandatory for every patient who presents with self-harm and should be done according to the NICE guidelines and the trust's self-harm policy.

The main objective of this audit was to determine whether the self-harm risk assessments undertaken within the service reflects the standards set within the NICE guidelines and the trust self-harm policy as well as to address any gaps, if present.

The other objectives were to evaluate the cases in terms of demographics, risk assessment undertaken and care plan.

Standards:

The standards for this audit were set 100% according to the RDASH Self harm Policy v6 based on NICE guidelines.

The Following points were assessed from the policy:

Number	Criteria	Standard
1	Assessment of Need	100%
2	Risk Assessment of Self harm	100%
3	Care plan with regards to Risk	100%

NICE recommends that everyone who has self-harmed should have a comprehensive assessment of needs and risk. The assessment outcome should form a collaboratively agreed plan of care with the patient that should include a crisis and contingency plan.

Method:

This was an observational retrospective study conducted by qualitative review of 10 random assessments completed by various professionals (CAMHS practitioners, Nurses, Doctors) following an acute presentation of self-harm.

The results were gathered through a data collection tool (Excel sheet) following review of the electronic records on system and then compared with the standards detailed in the trust's self-harm policy.

Results

- The study found the mean age of presentation with self-harm was between 15-16 years of age with females (70%) and white British ethnicity (90%) predominant as compared to males (30%) and mixed British ethnicity (10%) , respectively. (Figure 1)

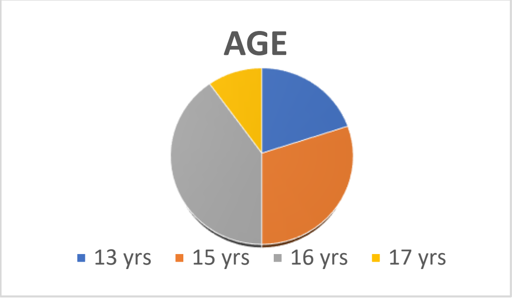


Figure 1

- 60% of the assessments took place in a Paediatric inpatient ward, followed by 20% each in A&E and at home. (Figure 2)

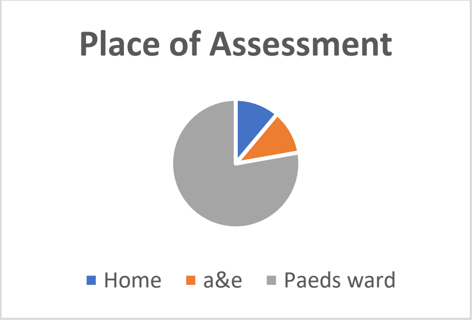
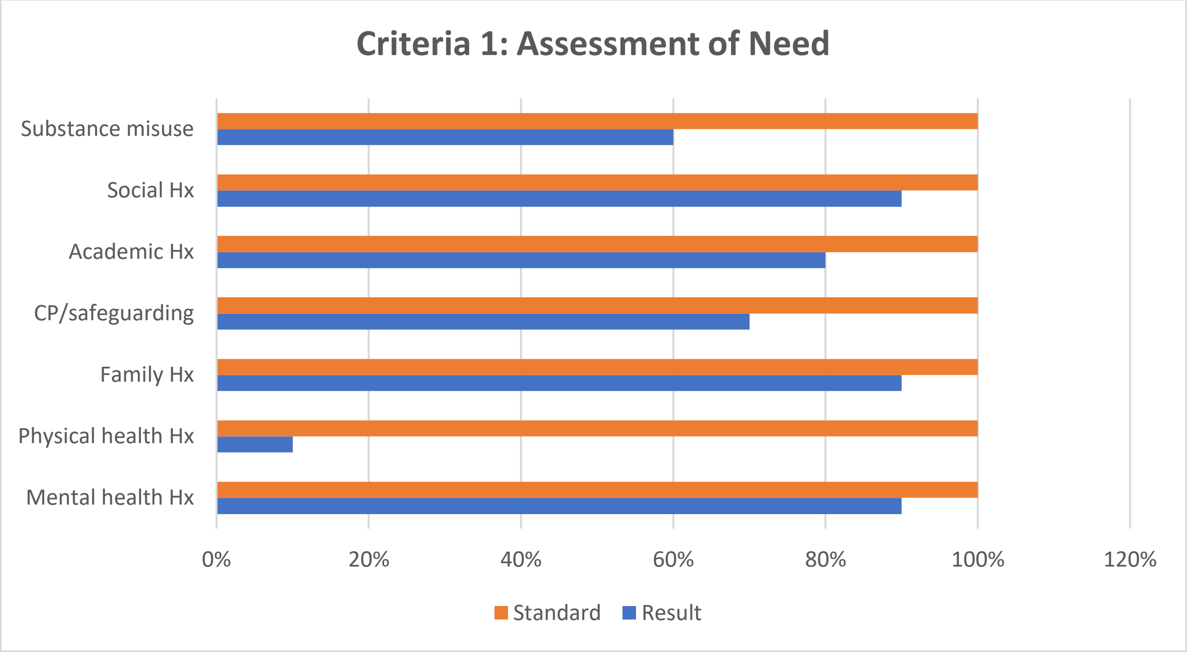


Figure 2

Criteria 1 : ASSESSMENT OF NEEDS **(Figure 3)**

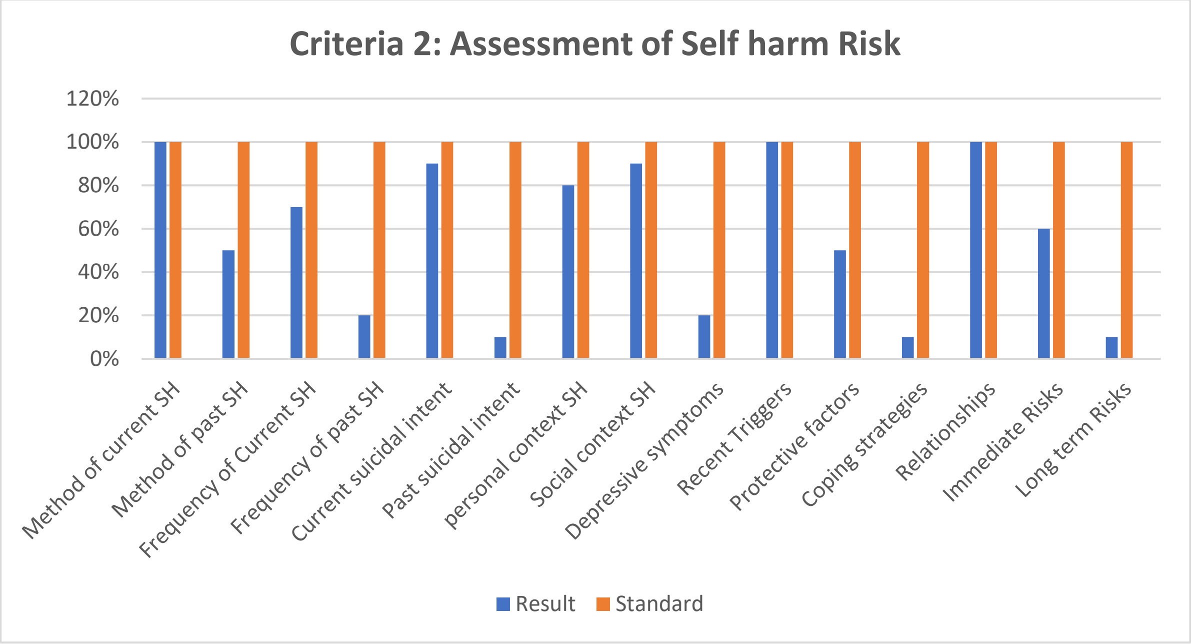
- Poor compliance with documentation of physical health status (10%), followed by substance misuse (60%) and Child protection/safeguarding issues (70%).
- Improved compliance was noted in terms of assessment of mental health status (90%), family history (90%), social history (90%) and Academic factors (80%).
- However, none of the standards reached 100% compliance.



(Figure 3): Criteria 1

Criteria 2: Risk Assessment of Self harm: (Figure 4)

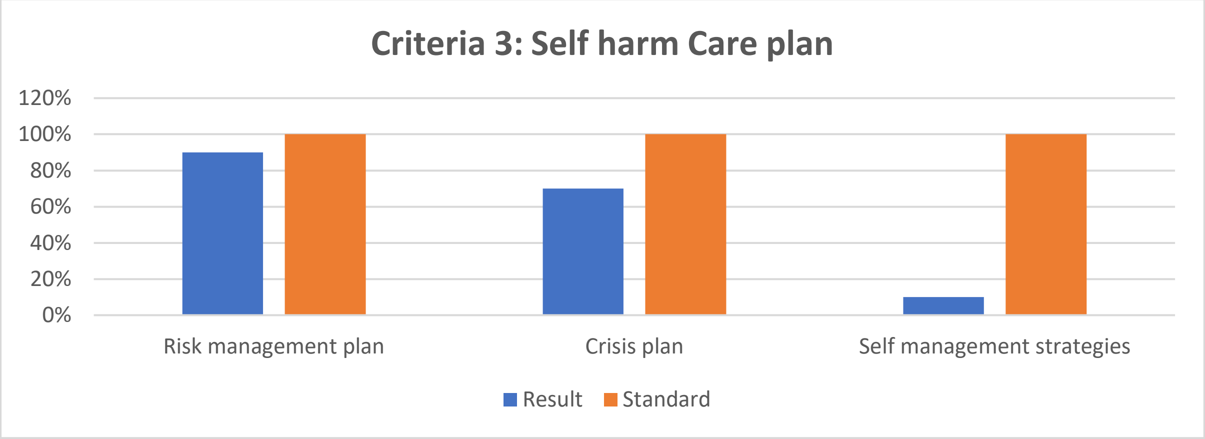
- A full compliance with the standards was noted in assessing the methods of current self-harm, the relationships affecting the self-harm and recent triggers.
- Poor compliance was noted in documenting coping strategies, past suicidal intent and long-term risks (10% each)
- There were poor documentation of depressive symptoms (20%) as well as frequency (20%) and methods of past self-harm (50%).
- Protective factors were discussed in 50%, immediate risks in 60% of the cases.
- Personal context of the self-harm was assessed in 80% and social context in 90% of the cases.



(Figure 4): Criteria 2

Criteria 3: Did the Care plan have: (Figure 5)

- 90% of the care plans contained a full risk management, on the other hand only 70% had a crisis plan documented.
- In only one case, self-management strategies was documented as part of the care plan.



(Figure 5): Criteria 3: Self harm care plan

Limitations

- A limitation of this audit is that consideration has only been given to what is documented in electronic notes of patients. If it was discussed but not documented, then it was not counted.

- Another limitation noted while data gathering, was that some parts of the assessments could not be completed due to patient's poor response/lack of engagement on account of difficult circumstances surrounding the presentation. This may have impacted the results.

- The FACE risk assessment tool was not audited alongside these assessments. This may also have had an impact on results as some professionals complete this tool alongside their usual assessment of self-harm whilst other professionals don't.

Discussion/Recommendation:

The audit showed significant rates of compliance with Assessment of mental health (current/past), Assessment of current method of self-harm, Recent triggers, Relationships affecting self-harm with the standards which is commendable.

An important finding however was the poor documentation of assessment of physical health status. This is an essential part of any review following self-harm as the care plan needs to be tailored to meet both the mental and physical health needs of the patient. This also forms an important standard of criteria 1 of the self-harm policy.

Another outstanding gap was the poor registration of depressive symptoms. It was noted during data gathering that most of the depressive symptoms documented were only 'low mood' and 'poor sleep'. According to the DSM 5/ICD-10, a minimum of 5 symptoms (low mood, loss of interest, significant weight change, sleep disturbance, psychomotor agitation/retardation, fatigue, feelings of worthlessness/negative thoughts, Reduced concentration, thoughts of death/self-harm) should be documented to assess depression.

Coping strategies and protective factors make an important part of the assessment while assessing future risk of self-harm. Both these were poorly documented during the assessments. Similarly, A Crisis or contingency plan needs to be documented separate to the risk management plan of any self-harm assessment, so the patients are aware what process to follow during a time of crisis.

A common practise during most assessments is also updating the FACE risk assessment during such episodes, however NICE clearly advices 'Not to use risk assessment tools and scales to predict future suicide or repetition of self-harm' and also 'Not to use risk assessment tools and scales to determine who should be offered treatment or who should be discharged'. Also, as FACE risk assessment tool does not cover all the criteria for self-harm assessment as set by the trust and NICE policy, we recommend there should be specific guidelines in place that professionals can follow whilst assessing and documenting self-harm assessments.

We have devised an information gathering sheet based on the NICE guidelines and Trust's self-harm policy v6 and recommend this template be followed for every Self harm assessment and should be completed alongside FACE risk assessment tool. The data gathering sheet has been incorporated in the junior doctor's induction booklet, so they are aware of the protocol to follow and also been distributed to the staff within the services.

REFERENCES:

Self-Harm-PC-and-SC-Services-Policy-v6.pdf (rdash.nhs.uk)

Overview | Self-harm | Quality standards | NICE

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(ii) NHS Digital / The Independent (January 2020) 'Number of children admitted to A&E with mental health problems jumps 330 per cent over past decade'. Available at: https://www.independent.co.uk/news/health/children-mental-health-hospital-suicide-nhs-ae-a9255626.html

(iii) YoungMinds (summer 2020) Coronavirus: Impact on young people with mental health needs (survey two). Available at: https://www.youngminds.org.uk/media/355gyqcd/coronavirus-report-summer-2020-final.pdf

(iv) NCB and UCL research (November 2020), 'One in six report severe mental health difficulties by age 17'. Available at: https://www.ncb.org.uk/about-us/media-centre/news-opinion/one-six-report-severe-mental-health-difficulties-age-17

(v) ONS: Deaths registered in England and Wales (2019) section six 'Leading causes of death'. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsregistrationsummarytables/2019#leading-causes-of-death
(vi) NHS Digital (2018) 'Mental Health of Children and Young People in England, 2017'. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017. Based on 46.8% of 17 to 19-year-olds that were identified as having a diagnosable mental health condition reporting that they had harmed themselves or tried to kill themselves at some point

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

Reflection on parenting in CAMHS

Annie Swanepoel

I visited the home of one of my patients with severe learning disability yesterday, as I could not understand why his parents were not following my advice. I am so glad that I did. I realised that his parents had mild learning disability themselves and that the advice I was giving did not make sense to them. I was also struck by their unconditional love for their son. They had no expectations of him and did everything they could to make his life as happy as possible. Their son, who is wheelchair bound and unable to speak, was basking in their love. He was without a doubt the happiest child I have ever seen in my role as Consultant Child and Adolescent Psychiatrist.

As I drove back from the visit, I was humbled. I thought about how I was parented and how I parent my children. I also thought about parents I had encountered before. I remembered a case from a few years ago, in which I saw a severely suicidal girl who boarded in a private Sixth Form, whose parents lived abroad. She told me that she hated her life. She loved art and wanted to be an artist, but her parents had decided she would be a doctor. She was made to take Chemistry, Biology and Mathematics with the plan to apply to study medicine at Cambridge. She told me that this was what her parents expected of her and that they had sacrificed so much, she could not refuse. I explained that I would need to inform her parents about her risk to herself and said that perhaps by talking to them, they would understand that the pressure they were putting her under was excessive and not conducive to her happiness. She sniggered and said they would not care. I arranged an international call to both parents and told the parents that their daughter had survived a suicide attempt but was still seriously suicidal. Both responded in unison, with fury, saying how they had given her a wonderful opportunity and she was now messing it up and that she needed to get a grip straightaway. Their only worry was whether she had missed any lessons at school.

Parenting is on a spectrum: from unconditional love with no demands on the one side, to high expectations with no love on the other. What will matter in the end? Children having more achievements and accolades, or having been accepted for who they are? I keep thinking where am I on that spectrum? Where are you?

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PSG meeting feedback

Nisha Balan

PSG met in May 2021 and Oct 2021

Work plan Patient Safety Group (PSG) post Meeting 8.10.21

Work Plan Review	Link with Mental Health Safety Improvement Programme Steering Group now formed Aims: Reducing restrictive practice in In-patient Mental Health and Learning Disability services Improving sexual safety within In-patient Mental Health and Learning Disability services Contribute to reducing suicides and episodes of deliberate self-harm for people using In Patient Mental Health and Learning Disability, Acute Secondary Care services and for staff working within our Healthcare systems.	**next on 27th Jan – identified members to attend**
Creative Conversations about Suicide	Working with Suicidal Ideation Possible future conversations: identified disenfranchised grief What I wish I had known in training	**Members to continue with this work**
SI Sub-Group	Video and invite to workshop produced, and sent out.	**Workshop on Friday 4th February 12-2** **Congress submission- Rachel will start.**
Review of Organisational Guidelines	Following the suicide of a patient	**To adapt the bit on family support post incident** **Emphasise legal support**
Co-production/ AsPICs	Link with Co-production group co chaired by Jacquie and Jon.	**Congress presentation: Safety is a co-created entity, Mary/Chloe with Rachel Chairing. Rachel will write and send round.** **Keep on the agenda** **Chloe Beale has been asked to do live presentation**
National Suicide Advisory Group	• Standing Item.	**Chloe Beale attending**
Next meeting	• 10th February 11-2	**Sarah Bates from Support After Suicide will be invited to attend**

SI sub-group Video and invite to workshop produced, and sent out – I could circulate the invite to CAPFAC

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

An open letter to Mr Javid

Dear Mr. Javid,

As a substantial body of consultant child psychiatrists working in the UK across multiple services, we are writing this open letter to express our deep concern about the state and funding of children's social care. At a time when deficits in adult social care are being considered, we are dismayed that there continues to be relatively little focus on the corresponding desperate state of children's social care provision.

Closely associated with this is the skewing of the much needed, wider public debate about children's emotional-wellbeing away from the social and cultural determinants of distress and mental illness towards a narrow, decontextualized child-centric view. This is particularly short sighted at a time of such disruption to social cohesion and collective trauma as the Covid-pandemic.

This may be politically expedient, but mental health does not exist in a vacuum, and the biggest risk factors for significant mental health need are undeniably social - in particular exposure to cumulative adversities such as poverty, domestic violence, victimisation, community breakdown, inadequate schooling and so on.

On the front line, dealing with the most vulnerable, distressed and risky young people, on a day-to-day basis, we see firm evidence of these social adversities at play, that mental health interventions can make little difference to, without the provision of adequate and secure family support and/or social care, necessary to engender stability and feelings of safety, and into which mental health providers can reach in where needed.

Added to this, is the harm caused by a societal response which views the, often understandable, emotional distress young people are experiencing as pathological. Such distress may be further exacerbated through placements in social and educational settings which at best do not meet their needs, or at worst are actively harmful. To respond as if there is something wrong with the child that needs to be 'fixed' only adds to shame and compounds the problem and indeed sometimes inappropriately trying to solve contextualised distress through therapy, or medication, can make matters worse or lead to chronicity, Even where differences in individual brains ("neurodiversity") may contribute to vulnerability, such vulnerability is wildly amplified by wider inequality, adversity and lack of appropriate educational provision and social care.

The resource implications of this shortfall in social care across the entire public sector are considerable, with such young people taking up vastly disproportionate time and expense, often involving the police and using acute general hospital admissions as last resort places of safety, in the absence of a more appropriate alternative. Such young people are, of course, understandably, very distressed and the tension between health and social care perspectives gets played out on a daily basis all over the country, with social workers often pushing for psychiatric admission, and psychiatrists calling loudly for social care needs to first be addressed before mental health intervention can have any chance of success. The public discourse portraying all emotional distress as a mental health problem in need of a health focused intervention raises unrealistic expectations of what can be achieved, for example through medication or hospital admissions, and becomes an obstacle to getting children and families the support they need to form a secure foundation.

In part, this may be an inevitable consequence of separate funding streams that disincentivises working together in the best interests of young people. This split might be best addressed in the long term by more joined up health and social care funding arrangements, as piloted in rare hot spots across the country. More proximally however there is a dire shortage of adequate social care provision at every level, not least for the most vulnerable groups (an index of which might be the provision of secure social care beds for young people at risk of recurrent absconding, exploitation and other harms: for every 20 applications made by the courts, we understand on average, one bed is available).

There may be ideological obstacles as well as practical. The process of identifying placements for children where in-family care cannot be maintained is a dysfunctional market. There is a brokerage system operated on market principles, but a market approach only works when there is flexibility in supply and demand to respond freely. The distortions due to the shortage of placements, inadequate staff training, lack of social care funding and the need at times to find placements quickly at times of crisis has led to a failure of the market. Added to this, the desperate shortage of staff in social care services means that placement searches and specialised commissioning are not functioning to meet the needs of the most vulnerable children.

We could go on with numerous other examples of concerns, at both preventative and post-care levels. There are a multitude of difficulties in children’s social care. A localised salary system with the most hard-pressed services unable to pay competitive salaries. An OFSTED led regulatory system paralysed by its aversion to risk and lack of understanding the social determinants of distress, so that a good residential unit can be threatened with closure because they accept a complex young person for whom there are inevitably going to be further risk incidents, at least in the short term, such that the young person effectively becoming ‘unplaceable’. Ill thought through regulatory changes regarding the use of unregulated placements which fail to consider the impact this has on further distorting the market are also problematic.

The thrust of our argument, however, is that while debates about funding for mental health provision are never unwelcome, in the current context we fear they distract from the far greater social drivers of mental distress and emotional need we are seeing every day going unaddressed in our clinical practice. It is perhaps politically expedient to locate the reverberations of family and social breakdown firmly in the presumed mentally disordered brains of individual children, rather than the accumulative fallout from increasingly socially-blind governmental policies that further disfranchise those already on the margins and associated break down in social and educational support structures. This approach will not solve the escalating levels of distress we are seeing in the young, but it may be more likely to drive an escalating demand for mental health services which cannot meet the needs.

It is time to start a national debate on how we respond to young people in crisis; a debate that addresses both well-established social determinants of emotional distress and newer challenges such as social media victimisation and internet safety, which have also been woefully neglected by successive governments. Please hear our plea to take a wider health and social care approach to halting what we fear will otherwise become an inexorable march of increasing tides of emotional distress in children and young people.

We will be circulating this letter widely to the press and anticipate a timely response.

Yours sincerely,

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
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Dr Hetal Acharaya	Trainee Representative
Dr Nicky Adrian	Regional Representative for London South West
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

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Dr Rory Conn	Elected member, RCP link
Dr Anna Conway Morris	Eastern, Regional Rep Lead
Dr Andrea Danese	Academic Secretary
Dr Ananta Dave	Safeguarding lead, Policy Lead
Dr Virginia Davies	Public engagement, CAPFEB chair
Dr Sharada Deepak	Regional Representative for Oxford
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Ms Rhiannon Hawkins	Participation consultant
Dr Thomas Hillen	Medical Psychotherapy link
Dr Siona Hurley	Regional Representative in Wales
Dr Shermin Imran	Regional Representative in North West, Psychiatrists Wellbeing
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
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Dr Jose Mediavilla	Elected member, QNCC representative
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Dr Karen Street	RCPCH link
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Dr Sami Timimi	Elected member
Mrs Toni Wakefield	Carer representative
Dr Joanne Wallace	Run through representative
Dr Susan Walker	Elected member, medico legal
Dr Justin Williams	Regional Representative in Scotland
Dr Sophia Williams	Trainee Representative
Dr Mark Rodgers	Chair of Faculty in Northern Ireland