

## **Faculty of Child & Adolescent Psychiatry Executive Committee Newsletter**

<b>Chair</b>	<b>Elected members</b>	
Bernadka Dubicka	Phillipa Buckley	Leo Kroll
	Rory Conn	Holan Liang
<b>Vice Chair</b>	Nicole Fung	Jose Mediavilla
Jon Goldin	Rajesh Gowda	Paramala Santosh
	Tina Irani	Louise Theodosiou
<b>Finance Officer</b>	Abdullah Kraam	Susan Walker
Alka Ahuja		

### **Co-opted members and observers**

Omolade Abuah	Clare Lamb
Nicholas Barnes	Elaine Lockhart
Prathiba Chitsabesan	Mark Lovell
Ann Collins	Guy Northover
Andrea Danese	Kiran Panesar
Ananta Dave	Nathan Randles
Virginia Davies	Karen Street
Suyog Dhakras	Fionnuala Stuart
Kristy Fenton	Toni Wakefield
Tamsin Ford	Birgit Westphal
Rhianon Hawkins	David Williams
David Kingsley	Richard Wilson
Marinos Kyriakopoulos,	

*In this issue**Louise Theodosiou*

Welcome to this special edition of the newsletter, I would like to take this chance to greet each of you and ask you how you are. I have been thinking a lot about this customary greeting, and the fact that I have never been asked the question with such sincerity until recent months, by the families I work with, my colleagues, my friends and my own family. I genuinely hope that you are all okay.

Do remember that there is lots of useful advice for clinicians, patients and families on the Royal College Website

[Responding to COVID-19](#)

Here you can find information about medication, remote consultations and advice for people with specific mental health needs.

This newsletter grew from an acknowledgement of the profound impact of COVID-19, however it feels vitally important to reflect on the death of George Floyd. I feel proud to be a member of a Royal College that has reiterated so effectively a total opposition to all forms of racism everywhere in the world. Finally, it feels important to recognise that this is Pride month, and that some LGBTQ young people may be living with parents or carers who do not know their gender or sexual identity, and thus they may be unable to join in any of the celebrations during this time. We are trained to listen, now more than ever we need to be listening to those children and young people who struggle to be heard.

Thank you to everyone who has taken the time to contribute to this newsletter. There is much to read and reflect on. Bernadka Dubicka, our Chair, charts the increase in mental health problems with a disproportionate impact on service accessibility for families with limited access to technology and the vital need for resources. Ananta Dave has shared her vital work in relation to COVID-19 and Black and Minority Ethnic mental health staff; I welcome the Risk Assessment Tool and the importance of reflecting on the fight against racism.

Thank you to Kristy Fenton for your report into the health inequalities in Wales that have been magnified by the Pandemic, to Elaine Lockhart for your insight into the challenges of delivering care in Scotland while maintaining the safety requirements of the pandemic and to Richard Wilson for your insights into the impact of COVID-19 on the people of Northern Ireland. Richard it has been so lovely to work with you in your time as CAP Chair in Northern Ireland.

It has been so wonderful to read all of the entries we received, with psychiatrists sharing their experiences of the pandemic. Thank you to Cornelius Ani for his valuable insights into the ethical challenges presented by COVID-19. Congratulations to Razan Halawa; her excellent essay was joint winner of the Harrington Prize, and the first of the two winning entries to be published. Guy Northover has shared valuable insights from his leadership roles during the pandemic, it is a pleasure to highlight Prathiba Chitsabesan's excellent blogs for NHS England, and of course the useful animated parenting tips shared by Andrea Danese. Thank you to Ruth Marshall for illustrating the selfless work undertaken by volunteers who have sewed scrubs for hard working clinicians.

We have all been trying to make sense of the pandemic. Thank you to Leo Kroll for providing a values-based lens through which to view our new and ever changing normal. Schwartz Rounds can be key space to explore the impact of clinical work; thank you to Rory Conn for his valuable insights, and to Dr Bloster for their honesty in reflecting the challenges for busy clinicians. As the pandemic has closed borders and forced people indoors, it has been liberating to follow Jane Whittaker's journey through fiction and into important personal and professional insights.

Thank you to Alison Flynn and Gabrielle Pendlebury for making visible the needs of vulnerable adolescents, and Kiran Panesar and Omolade Abuah for describing the Co-SPACE project which seeks to understand the experiences of parents and children during the pandemic. Finally thank you so much for the honest and thoughtful insights into working on call during the pandemic from Cosmina Cross and to Kathryn Speedy and Fifi Phang for their fabulously inventive and effortlessly empathic insight into life as a trainee.

We will be preparing the summer edition in the next month, if any readers feel inspired to share their experiences, we would be very pleased to hear from you. Remember that we as an executive group are here to represent you, do reach out we are keen to hear your voices.

**Dr Louise Theodosiou**

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**The chair's column****Bernadka Dubicka**

**An impending crisis for young minds** - Published in the *Institute for Art and Ideas* - Issue 88, 29th May 2020

*With the coronavirus pandemic adding fresh weight to already struggling mental health services for young people, we must urgently realise the cost of overlooking young minds. A worsening mental health crisis among younger generations will exacerbate the economic burdens to come, and could have impacts which reverberate long into the future.*

*Mental health services for children fail to meet soaring demand: The ongoing crisis is evidence of systematic discrimination against children.*

These are words that I wrote almost exactly three years ago. Now I sit here reflecting on our current coronavirus crisis and what it means for our young people.

Before we think about the impact of this crisis on the mental health of young people, let me set the scene pre-Covid-19.

Back in 2017, our editorial in the BMJ lamented the miserable progress on supporting our children and young people (CYP) with mental health problems in the UK over the preceding two decades, since the publication of a seminal report 'Every Child Matters'. For example, although 75% of mental health problems start in childhood and adolescence, historically only 6% of our mental health budget has been allocated to CYP.

**Even before the virus there was evidence that our children were experiencing ever increasing mental health problems.**

So, what has been the progress over the past three years in demonstrating that every child does actually matter? There's some good news. Within England (and similar work elsewhere in the UK), we welcomed the publication of the government's green paper pledging to install mental health teams in schools, and work has started at pace, with the aim of covering the whole of England within the next 10 years.

There's a lot that can happen to a child over a decade. Our children need more, a lot more and a lot sooner. As we wait to see how the impact of this pandemic unfolds, it does not take much of a stretch in imagination to foresee that the existing mental health burden is only going to rise, with potentially ever greater numbers of CYP waiting for help. Getting support in schools will also be vital as many frightened, and some traumatised children make their way back to education. Some of these children will have suffered enormously through the impact of living in lockdown, with no respite from abusive parents, domestic violence or living with a parent with a mental illness or addicted to alcohol or drugs.

Even before the virus there was evidence that our children were experiencing ever increasing mental health problems. Take the recent prevalence survey from the government (which took over a decade to be funded, NHS digital 2018): emotional problems were on the up and over half of older teenage girls with a mental health disorder are self-harming. That is *more than 50%*. The worry now is that this rate is likely to climb even higher due to this crisis as young people struggle to cope with fears for their future. Rates of self-harm and suicide rose during the global recession (Fegert 2020), however, that did not bring all the additional burdens of this pandemic such as isolation, loss of education, and the fear of contagion, illness and death.

**Social advantage does not preclude mental health problems, but it certainly acts as a buffer for some. Tragically, that buffer will have now been removed for many as a result of the economic devastation of the pandemic.**

Prior to covid-19, this long-standing demand for chronically under-invested services has been the straw that broke the camel's back, along with massive workforce shortages. For example, 15% of child psychiatry posts remain unfilled, and a BMA survey of the mental health workforce in January (BMJ 8.1.20) reported that 63% worked with regular gaps in the rota. There is a government NHS 10 year plan, again with very welcome aspirations; however, it has never been clear how these aspirations will be met, and particularly without a joined-up approach and investment throughout the whole of government, including social care, education and youth justice, as well as tackling the issues behind the chronic workforce shortages. In light of the pandemic, this plan not only needs to be urgently accelerated but also reviewed with up to date data on what is happening to our younger generation as a result of this crisis.

Before the pandemic, I was often asked why it is that our young people seem to be suffering more than ever from mental health problems. I'd like to tell you for sure but again, we need properly funded government research over time. That funding has sadly not been forthcoming to date. Social media is often cited as a potential reason, and although it may have a part to play with some of our more vulnerable CYP (college report 2020), technology has been a lifeline for many during this crisis. Social media is certainly not the main driver for the suffering that I see in my everyday practice; instead I see children that have been neglected, abused, traumatised, and those that struggle in society with conditions such as autism or learning disabilities with minimal support.

During this lockdown many of these children have suffered and some have had no way of escaping the day to day trauma of their everyday lives. Social advantage does not preclude mental health problems, but it certainly acts as a buffer for some. Tragically, that buffer will have now been removed for many as a result of the economic devastation of the pandemic.

Before corona, there was plenty of evidence of the impact of an increasing social divide on mental health problems. For example, last year a study from Cardiff published in a European journal showed the impact of austerity in the UK on the mental health problems of our poorest children. The Marmot report (2020) found that in some areas of England more than one child in two is growing up in poverty. Imagine my shame when on a trip to Poland earlier this year, my Polish colleagues kept asking what was happening in the UK, as they were seeing so many families returning to Poland telling them that they could not access CAMHS in this country. How did we get here? A question that has also been asked about our corona crisis.

**Rather than moving towards health equity, coronavirus has opened a further chasm in our social divide.**

So what now? We have an acute crisis upon a stagnant chronic disinvestment in our future generations. And we are also a country which is hardest hit globally in terms of the impact of the pandemic. It is too early to know exactly how our young people will be affected, but the early signs are not good. Rather than moving towards health equity as the Marmot report called for, coronavirus has opened a further chasm in our social divide. Youth unemployment, future prospects for our young, and the impact of parental unemployment and its consequences as well as the direct impact of the virus on trauma and bereavement, will take a big toll. Young people are already being disproportionately affected by loneliness during this crisis. We know how poverty impacts on mental illness. It doesn't take much to extrapolate what is happening now and what will be needed to support our young people in the aftermath of the pandemic.

Three years ago, in the BMJ paper I called for a societal approach to mental health, which is echoed by many reports, including Marmot who called for a reordering of national priorities to give every child the best start in life. The economic case for early intervention and prevention has been made time and time again. Take autism: the national cost of supporting someone with autism is more than that of heart disease, cancer & stroke combined (Buescher 2014) but children with autism and their families often struggle to get any support. Early intervention is vital to offset these costs and to prevent CYP falling into crisis at huge personal and societal cost. Equally, providing support for our most vulnerable children and young people now, before the full economic impact of the pandemic takes hold, may go a long way to providing that necessary buffer and help them to thrive.

Surely, if ever there was a time for reviewing our national priorities, for investing in the next generation, our economic future, and reducing this great divide, that time has to be now. And if not now, then when? I would like to think that as a society we do believe that every child does matter.

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## ***Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings-assessment and management of risk***

**Ananta Dave**

*A moment to pause, feel and regroup*

- #BlackLivesMatter
- *Injustice anywhere is a threat to justice everywhere.*
- Staying silent is not an option.
- Those who have the voice and energy to stand up for colleagues, friends, families and communities, the time is now to do what we can in our sphere of influence

The Royal College of Psychiatrists has responded to the urgent issue of the high and disproportionate numbers of deaths of BAME staff due to COVID-19, by producing initial guidance on risk mitigation for urgent implementation across all mental health care organisations in the UK.

**The full report can be accessed here:**

[Impact of COVID-19 on BAME staff in mental health care settings](#)

**It is a starting point, where do we go next?**

### **Mental healthcare workforce**

As per the HSJ article 19/5/20, eighteen (11 per cent) individuals worked in a mental health setting, while mental health staff account for 18 per cent of NHS staff. 39% of RCPsych members and 33.3% of doctors on the GMC register are from a BAME background.

### **What we say and how we say it matters - our approach**

- BAME does not refer to a homogenous group of people
- It is necessary to understand each person's identity and unique story
- Be careful that terms don't exclude, 'other' or depersonalise people.
- The term 'underlying health conditions' may also indicate underlying or overlying attitudes

*When compared to previous years, we also found a particularly high increase in all causes of death among those born outside the UK and Ireland; those in a range of caring occupations including social care and nursing auxiliaries and assistants. (PHE report on disparities)*

**Understand the person - a starting point. How do we identify and understand the impact of structural inequalities and discrimination?**

- An organisational approach
- [Risk Assessment tool for staff during the COVID-19 pandemic:](#)

**What is the risk assessment tool?**

- An aid to a sensitive collaborative conversation



- To provide structure and guidance to agree on a plan of action to reduce risk

**What it is not:**

- Not for use as a tick box exercise
- Not an end in itself
- Not a categorical tool
- Not a scoring checklist

**A need to reframe and rephrase?****Recommendations/ways forward -1**

- Accurate data on staff deaths - who collects and has oversight?
- Ethnicity recording on death certificates.

*In the future we should have no public database that can't be analysed by ethnicity* (Professor Louis Appleby)

- Learning from deaths
- Learning from areas of good practice
- Using the right language matters
- Provide training to develop and support compassionate, collaborative and culturally sensitive leadership behaviours

**Recommendations/ways forward -2**

Making a stand against racism and working to end inequalities and inequities is a core part of College business. It speaks to the key strategic aims of RCPsych- improving outcomes for patients, sustainable workforce, promoting equality, diversity and inclusion.

**How can we hold ourselves to account and give confidence that we are doing what we can?**

- Listening to the voices of people who live the experience, narratives, stories are important
- Speaking truth to power in the national arena

**References**

Health Services Journal. [Exclusive: deaths of NHS staff from COVID-19 analysed](#). [Accessed May 2020]

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## Report from Wales



**Kristy Fenton**

COVID-19 in Wales is having a significant impact upon children's mental health. Wales has high prevalence of poverty, substance misuse and health inequality, and these are being magnified by the pandemic. We know that as parents face difficulties with their income or suffer job losses this will place strain on the relationships within families. These strains on families have been highlighted in [Public Health Wales' "How are you doing?" survey](#).

I had the opportunity to discuss how families and children, especially those with neurodevelopmental disorder or serious mental illness, are responding to COVID-19 earlier this week at the Welsh Parliament. I gave evidence through Zoom to [the Children, Young People and Education Committee](#). This was a great opportunity to discuss what needs to happen in the future, air some concerns but also speak positively about the changes that have been made in Wales. It's clear that just as we are living in extraordinary times, there have been extraordinary responses to the pandemic in Wales.

Prof. Alka Ahuja – our public engagement lead in Wales – has been leading the role out of video consultations as clinical lead on the Technology Enabled Care (TEC) Cymru programme. Across all of healthcare, 10,00000 digital consultations have now been performed. The initial Connecting with Telehealth to Children in Healthcare (CWTCH) pilot, that was endorsed by RCPsych Wales, informed the work of the national programme. CWTCH have developed complimentary guidance, and a toolkit for Telepsychiatry. We've also hosted a webinar with TEC Cymru on conducting video consultations and telepsychiatry and these [can be found on our website](#).

In addition to technological improvements, there seems to be no end of resources created in Wales which help to understand and better manage the impact of COVID-19 on children. The Children's Commissioner for Wales has produced a significant survey of over 23,000 young people's thoughts and feelings, which will go some way to understanding what support they may need. In addition to the toolkit that Welsh Government have themselves produced for young people, we've promoted online resources for children and young people with ASD and ADHD, that have been developed by the tertiary neurodevelopmental service at Aneurin Bevan Health Board. Additionally, Dr Sharifah Shameem Agha, Dr Kate Langley, Catrin Hopkins, Dr Rhys Bevan Jones and Prof. Anita Thapar have also produced a wonderful animation explaining ADHD as part of a research project at Cardiff University. Finally, Prof. Ian Jones at the National Centre for Mental Health has adapted his bipolar psychoeducation programme to help people manage COVID, and we anticipate that there may be a

useful application in this programme for helping children and young people with Bipolar Disorder to engage with other young people. The Welsh College has endorsed this particular programme.

Resources and support for children and young people will be a useful supplement over the next couple of months. It's now been announced by the Welsh Government that Welsh pupils will start returning to school on the 29<sup>th</sup> June for 'Check In, Catch Up and Prepare for summer and September'. Unlike in England, schools will be open to pupils from all year groups for limited periods during the week but a third of students are allowed in school at any one time. The return to school presents a number of challenges, as I'm sure many of my colleagues across the UK have faced, some of these I was able to highlight in the evidence session at the Senedd. It's important that children are able to reconnect with their peers, but it's also important that teachers are considered and supported to feel confident in their role, so they can be psychologically minded for students who may themselves be anxious. Along those lines, the Welsh Government announced £5m of funding to support mental health in schools. This includes support for the mental health of under 11s and teachers, for the first time.

As Wales progresses cautiously towards a new normal, so too are we returning to work that we put on pause at the start of the outbreak. That includes hosting meetings to look at transitions between child and adult services. With the addition of the flexibility that Teams provides, members of our Wales Child and Adolescent faculty met with our adult colleagues to discuss guidance that the Welsh Government had published. It was an interesting meeting and will undoubtedly be helpful in providing feedback to the Welsh Government hopefully as a small element of a much greater conversation about how CAMHS will look, post-COVID-19.

Recent times have certainly been challenging, both professionally and personally. I continue to be impressed by community resilience and recovery, the support that people have shown each other is heart-warming. The message of kindness and compassion to both others and ourselves has been resonating throughout our teams, and the young people and their families we support.

From Wales, we would like to wish all our colleagues who have been affected by COVID-19, through the loss of loved ones, being separated from their families, who have had difficult decisions to make, to readjust their priorities, and many other challenges that have impacted on us all...we wish you good health and happiness.

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## Report from Scotland



**Elaine Lockhart**

### *Working in the time of Covid-19 - "I'm not loving it"*

I'm writing this while wearing surgical scrubs. The last time I wore them was when I worked in Obstetrics and Gynaecology in the 1990's. This was not a post I relished, pipped only by my stint in a gherkin factory in Hamburg one rainy summer, on the list of all time least favourite work. This was for a variety of reasons, but the main ones were the 1 in 4 rota with a lively labour ward at night and working in a gynae clinic packed full of mostly unhappy women. They were not best served by 10 minutes of a solely biological approach to their difficulties. Happily, my next post was in psychiatry where I was encouraged to spend time with patients and to think about them holistically which suited me a whole lot better.

Anyway this is what we've come to, needing to wear scrubs, and on some wards, gloves, masks and aprons to see children and young people in the children's hospital. Fortunately Covid-19 has not taken its toll on children, with small numbers testing positive and no deaths under 15 years in Scotland. We do however need to wear the right PPE for those who are sick and it's a challenge for us to adapt our therapeutic approach with most of our faces covered while wearing anonymous scrubs. For those who are in-patient or are shielding, the loss of physical contact with families, friends and pets is hard going and there is no end in sight. Our work is also changed utterly with the need to socially distance ourselves from patients and colleagues. The hospital has been uncannily quiet with only on call paediatric staff coming in.

The speed and extent of how our services were transformed in the early days of Covid-19 is remarkable when we consider how in the past changing the NHS has been described as trying to turn an oil tanker. Categorising patients according to clinical need, moving from face to face consultations to working through telephone and video consultations and covering gaps in rotas was achieved around Scotland in just a couple of weeks.

The CAMHS medical workforce here has shown resilience, flexibility, creativity and positivity over the past few months. So, when I write that I am not enjoying my work as before, feeling like my usual Technicolor working world has been rendered sepia, these are my wistful musings alone.

I miss the hurly-burly of working in a busy place full of families and staff barrelling around corridors and clinical areas. I miss joining packed clinical meetings and impromptu chats over coffee .I miss working with families where our training, senses and physical presence allow us to connect intensely with them.

Our team does still meet each week, as many of us as can fit into a large room with socially distant desks, but no chocolate is passed around and there is much use of hand sanitiser and wipes. No chocolate!

These are indeed minor travails when compared to the reality of managing the Coronavirus in adult acute care settings. That the virus and the response to it affect disproportionately the most vulnerable among us is deeply troubling. It seems egregious to enjoy days at home which can only be described as idyllic during the exceptional weeks of sunshine in the west of Scotland. What is the word for the opposite of Schadenfreude? Weltschmerz perhaps? The Germans do seem to have come up with some of the best words for complex emotions in the English language?

So as we ease out of lockdown into this new normal, we will need to continue the new way of working for the foreseeable future. I will never get to like it, but I am grateful to my fabulous colleagues, patients and families who have adapted heroically and will carry me along. Just as long as no-one says that technology is the answer to everything and no gherkins are involved.

**Dr Elaine Lockhart**

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### ***Report from Northern Ireland***



**Richard Wilson**

*Seeing through a glass darkly; some reflections on the Coronavirus Pandemic in Northern Ireland.*

The COVID-19 pandemic reached Northern Ireland on 27<sup>th</sup> February 2020; as of today 15<sup>th</sup> May, five hundred and forty-one of our people have lost their lives due to the virus and we mourn their loss.

The world has been turned upside down in ways we would never have predicted: the effects of the illness on families and loved ones is profound. All of us have been touched at least indirectly, not least

in our working lives and by the necessary changes in civil liberties we have undertaken to attempt to



1 Newly ploughed field, Co. Antrim at start of lockdown, March 2020

mitigate the spread of infection. At every stage there has been uncertainty as the population, including health service staff, have faced the evolving unknowable, guided by constant arrival day by day of experiential data from around the world and attempts to formulate rational advice based on this information in a situation largely beyond human control.

In Child and Adolescent Mental Health Services the immediate consequences for our work have been enormous. As has been the case everywhere, business as usual in Northern Ireland abruptly disappeared at the start of the lockdown in late March. There was a significant downturn in referrals in some areas to 10-20% of that expected for the yearly pattern. Routine work was in the main fairly rapidly shifted to remote, technology assisted mode whilst crisis and some essential urgent work was maintained directly via social distancing with PPE, a most unfamiliar approach for the practice of psychiatry. Despite initial fears the supply of PPE has been generally adequate.

Leadership and communication have been severely tested during the past two months. Locally and nationally new structures and fora have been established along the chains of command and support. These have had necessarily to operate virtually which for those, including myself who prefer a hands-on approach, has been challenging. Communication has generally been excellent with a good sense at all levels of staff supporting one another and sharing in constructive ways. So far plans for widespread redeployment have not had to be progressed. I do know of some situations however where co-opted medical and nursing students have struggled in unfamiliar clinical areas where lines of support were not entirely clear....it has neither been straightforward nor easy.

With the apparent 'flattening of the curve' in N. Ireland in the third week in April our focus has been on the next stage i.e. whilst keeping patients and staff safe and continuing to keep to the public health advice, how do we begin to realign our services towards recovery? The NI Department of Health & Social Care (H & SC) have set up a Gold, Silver and Bronze system of strategic and operational groups to manage the process. Our Vice Chair Dr Mark Rodgers was co-opted on to the Silver Cell group which is developing the Children's Services plan at speed. Last week our Health Minister, Mr Robin Swann announced a bold plan on the rebuilding of our H & SC Services in Northern Ireland. RCPsych NI will be responding to the proposals on Monday, including drawing attention to the fact that outstanding resource issues prior to COVID-19 require to be addressed in this forward strategy.



RCPsych NI established a weekly Covid19 Reference group in March and it has proved a useful resource for consultant staff and trainees across the Province during this time on COVID-19 related issues and staff support.

As ever I have had excellent support and advice from many colleagues on the UK executive committee. It is also encouraging to see that important work on the development of Faculty strategy and the big beast of reviewing *Building & Sustaining Specialist CAMHS* is continuing apace...it has been a great privilege and valuable learning to have participated in these activities. I move into my new role as Chair of RCPsych NI at the end of the month. Unfortunately, the COVID-19 experience has meant my preparations have been totally altered though I have been able to meet with some of the other Faculties virtually at least.

Again it is hard to know what comes next. Will we be back in our clinics soon? What additional problems will our patients have faced due to the pandemic experience? I try to remind myself that as a psychiatrist I am well trained to bear the anxiety that uncertainty brings and not to expect that it will be in any way easy. At such times I find it helps to reflect on fundamentals. Not to get overly existential but still to try to focus on core values of respect, kindness, person centredness and evaluation of evidence both critically and honestly. It is probably unwisely early to try to construct frameworks of meaning or learning from the pandemic experience though it is certain that there will be a diversity of opinion especially perhaps in terms of leadership, preparedness and ethics.

As one of my own reactions to stress is to read more, I happened at the end of March, just as the lockdown hit to rediscover AE Housman and I was struck by the aptness of the following:

#### **Blue Remembered Hills:**

Into my heart an air that kills  
From yon far country blows:  
What are those blue remembered hills,  
What spires, what fields are those?  
That is the land of lost content,  
I see it shining plain,  
The happy highways where I went  
And cannot come again.  
A E. Housman



Some years ago I attended an event in Belfast on the psychological effects of war. Simon Wessely was a panel member and his words have stayed with me. He said ``War changes people`. That comes back to me at this time as we look forward anxiously to the next few months and years. What will be the meaning of the pandemic experience for us, for society, for the profession? How might we be changed by it? Perhaps there will be as many meanings as there are survivors? I don't know. In the vast corpus of post traumatic experience literature another guiding light to our feet is the work of another of our own.

Viktor Emil Frankl was an Austrian neuropsychiatrist and a Holocaust survivor of four of the German death camps including Auschwitz. He attributed his survival and recovery largely to his repeated efforts and struggles to find meaning in the inescapable horror which he experienced. His writings especially his book, *Man's Search for Meaning* (1946) outlining his philosophy of survival and recovery, always relevant to psychiatric thought and practice are perhaps particularly so at this time. I will leave the parting words to him in the hope that this light will illuminate the darkness.

*When we are no longer able to change a situation we are challenged to change ourselves.*

And finally

*I grasped the meaning of the greatest truth that human poetry and human thought and belief have to impart: The salvation of man is through love and in love.* Viktor E Frankl (1905-1997)

Thank you to everyone who has supported me in my time as CAP Chair for Northern Ireland. It has been an honour to serve and a time of great personal happiness and growth for me.

**Dr Richard Wilson**

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### ***Helpful advice during the pandemic***



**Prathiba Chitsabesan and Louise Theodosiou**

One of the repeated requests during the pandemic has been for thoughtful and practical advice. I am so grateful to Prathiba for the excellent blogs she has provided during the pandemic. These blogs provide guidance for young people who are feeling overwhelmed at this time

[What to do if you're a young person and its all getting too much](#)

There is also guidance for parents and carers who are concerned about children and young people, including signs to look out for and links to other useful resources.

[Advice for parents, guardians and carers on how to help and support a child or young person with mental ill health](#)

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## ***Some ethical issues associated with COVID-19 and Child and Adolescent Mental Health in the UK***



**Cornelius Ani**

The COVID-19 pandemic has caused the most profound societal disruption not seen in the UK for many decades. The high level of death and distress occurring within a matter of weeks is difficult for many people to come to terms with. While direct COVID-19 related mortality among Children and Young People (CYP) has been relatively low, the adverse impact on their wellbeing has been high in other ways.

The COVID-19 pandemic has triggered a number of ethical and practical challenges for clinicians working in Child and Adolescent Mental Health Services (CAMHS). These challenges include supporting CYP and families who have experienced losses of loved ones, dealing with clinicians' own losses of family members and or colleagues, continuing anxieties about personal safety, adapting to different ways of maintaining service provision, and planning for return to what has been described as the "new normal".

With over 41,000 deaths<sup>1</sup> in the UK due to Covid-19, it is likely that some CYP who use CAMHS have lost close relatives or people known to them. Some CYP may have also lost professionals who were providing support for them such as teachers. Similarly, many CAMHS clinicians have suffered losses of loved ones, and in some cases, colleagues. Even the CYP and clinicians who have not lost persons known to them may have vicariously felt bereaved and traumatised by the huge scale of deaths due to the pandemic. Thus, many CYP who use CAMHS may need additional help to deal with these losses. This may include CYP whose original purpose for using CAMHS may be for other more specific reasons such as for ADHD treatment. Clinicians would need to start having open and wider conversations to allow distressed young people the space to explore losses and be offered the help they need. Where the clinicians' skills or the CAMHS commissioned remits do not include extended bereavement counselling, the affected CYP could be referred to organisations such as CRUSE<sup>2</sup> and Winston's Wish<sup>3</sup> that can offer bereavement support. In addition, many areas of the UK have other local Organisations that provide bereavement support for CYP.

<sup>1</sup>

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deaths-involvingcovid19uk/deathsoccurringbetween1marchand30april2020>

<sup>2</sup> <https://www.cruse.org.uk/>

<sup>3</sup> <https://www.winstonswish.org/>

Clinicians who have experienced losses also need to consider seeking help in their own right. Being an experienced CAMHS clinician provides no immunity to difficult human experiences. Clinicians have an ethical duty to self-care<sup>4</sup>. Seeking help is not only in the interest of clinicians but it is also helpful to their work. After all, an ill clinician is less able to help CYP with mental health difficulties and is less able to support their own colleagues. NHS Trusts have their own in-house support for their clinicians. For clinicians who prefer accessing support outside of their NHS Trust, alternative sources include NHS support line (0300 131 7000 or text FRONTLINE to 85258), the British Medical Association<sup>5</sup> and the Royal College of Psychiatrists<sup>6</sup>.

The scale of COVID-19 related death and the high infectivity rate has left many people understandably anxious about their personal safety and that of their loved ones. Watching the daily government updates can heighten this anxiety as it is a continued reminder of how serious the infection is. It is important for clinicians to remind themselves that anxiety in this circumstance could be normal and even helpful. Normative anxiety could help clinicians to take necessary precautions to improve their own safety and those of their loved ones, and to consider the safety of the CYP and families they care for. Clinicians may also need to sensitively support CYP using CAMHS to understand that normative anxiety is not unusual and could be helpful in this case. Sometimes, it is okay, not to feel okay. Parents who are worried about their children's COVID-19 related anxiety may enquire about possible medical treatment to reduce the anxiety. In the absence of other more usual indications for medication, explanation and reassurance may be more helpful than medication in such cases.

As the COVID-19 infection rates and mortality continue to drop in the UK, some CAMHS clinicians' anxiety may still be high because of worries about loved ones living in other parts of the world where COVID-19 mortality is still rising. This is more so for clinicians originally from some low and middle income countries in Asia, Africa and South America where the pandemic is yet to peak and where resources to treat affected persons and reduce transmission are much more limited than in the UK. It is therefore important that clinicians do not judge how their colleagues are coping with COVID-19 based on how they themselves are coping. This is because some CAMHS clinicians may still be acutely affected by COVID-19 related events occurring thousands of miles away from the UK.

Use of Personal Protective Equipment (PPE) and social distancing are crucial elements in maintaining personal safety from COVID-19. However, these measures can also throw up a number of practical and ethical challenges for CAMHS clinicians. For example, PPE makes it difficult to use facial expressions to support psychotherapeutic interventions. A young person who is already distressed and suspicious perhaps from a psychotic illness may experience increased distress by seeing clinicians in PPE. For CYP already anxious about COVID-19, seeing clinicians dressed in PPE can be an acute anxiety provoking reminder of the risk associated with the virus. These anxieties may increase with the new government directive that requires services users attending hospital or clinic appointments to wear face coverings. Talking while wearing a face covering can make the person's voice muffled and difficult to understand. Thus where the clinician, and the CYP and their carers are all wearing face

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<sup>4</sup> <https://www.gmc-uk.org/registration-and-licensing/join-the-register/before-you-apply/guidance-on-declaring-health-issues/your-health-and-patient-safety>

<sup>5</sup> <https://www.bma.org.uk/advice-and-support/covid-19/your-health/covid-19-your-wellbeing>

<sup>6</sup> <https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service>

covering, having a therapeutic conversation could be potentially difficult. Therefore, for purposes of clarity in clinical conversation, the option of face to face meeting with face covering needs to be carefully balanced against the alternative of remote video meeting. The consideration needs to include the CYP and their family's choice, as well as whether a physical examination is crucial. The latter point may apply to a young person with a severe Eating Disorder who is at risk of physical complication. It is important to remember that the requirement to wear face covering does not apply to CYP with breathing difficulties such as those suffering from asthma, and young children under the age of 3 years. The Government guideline also exempts children who may find it difficult to manage face covering correctly. The latter group could include CYP with Autism Spectrum Disorder (ASD) who may struggle with face covering due to sensory difficulties.

Some of the concerns about how PPE and social distancing interfere with clinical interaction could be mitigated through remote clinical delivery. Thus COVID-19 has led to rapid and widespread use of digital service delivery in CAMHS. Indeed, remote working has developed so well in a short time that some NHS Trusts are now able to use it for Mental Health Act Assessments. Apart from helping to limit COVID-19 transmission, remote clinical contact has been helpful for families with limited access to transport who would otherwise have struggled to attend clinic appointments. However, remote working has also brought up its own practical and ethical challenges for CAMHS clinicians and service users.

In relation to clinicians working remotely, some face the challenge of not having the infrastructure such as adequate broadband speed in their telephone package. Other clinicians may not have the physical space to work from at home without interference by other family members such as young children. Clinicians working with CYP with conditions such as ADHD and Eating Disorder that require physical health monitoring may find digital clinical delivery more challenging. Whereas some employees in other sectors were already set-up for working from home prior to Covid-19, this was not often the case in CAMHS. Thus, for many CAMHS clinicians, COVID-19 led them to start "*working while at home*" which is not the same as "*working from home*".

Remote working has also brought about ethical challenges for families using CAMHS. Similar to clinicians, some families do not have the infrastructure, equipment and private space to engage with remote clinical support. Some families with non-inclusive telephone tariffs have incurred unexpected huge bills following remote digital appointments. Unfortunately, the most disadvantaged families who need the most help from CAMHS are also the most likely to face these challenges. These difficulties have left many clinicians concerned about the inequities engendered by digital service delivery. It has also emerged that some families are experiencing video appointments as disconcerting intrusions into their household.

The epidemiology of COVID-19 has shown clear higher mortality rates among people of Black, Asian, and Minority Ethnicity (BAME). This data has been used to inform staff risk assessments such as the version recommended by the Royal College of Psychiatrists<sup>7</sup>. The higher COVID-19 mortality among people of BAME background poses additional ethical challenges for CAMHS clinicians. Services with a

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<sup>7</sup> <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/risk-mitigation-for-bame-staff>

high proportion of staff from BAME background may have more clinicians who have already experienced disproportionate losses from the pandemic. This staff group may also have more worries about the safety of their loved ones living in other countries where COVID-19 mortality is yet to peak. In addition, the extra risk due to BAME origin may increase the number of staff needing risk-mitigation measures such as reduced face-to-face working. If a large proportion of staff members require such mitigation, the availability of clinicians for necessary face-to-face appointments may become limited. Also clinicians from BAME background who are advised to do less face-to-face work may feel guilty about leaving extra work for their non-BAME staff colleagues.

The new ways of working and the drastic changes to methods of service provision engendered by COVID-19 have left some CAMHS clinicians wondering if they are providing “good-enough” services compared with prior to COVID-19. Some clinicians are also concerned that adverse events related to the new ways of working may result in complaints against them. These worries are understandable. However, it is important to remember that judgement of what is good enough practice is context-dependent. It therefore follows that comparing the adequacy or otherwise of practice during the COVID-19 period with optimal practice prior to the pandemic may not be fair or appropriate. This is reflected in the statement issued by the General Medical Council and the other statutory regulators of health and care professionals in the UK at the start of the pandemic acknowledging that *“We recognise that in highly challenging circumstances, professionals may need to depart from established procedures in order to care for patients and people using health and social care services”*<sup>8</sup>. In order to provide further reassurance to professionals, these regulatory bodies added *“We recognise that the individuals on our registers may feel anxious about how context is taken into account when concerns are raised about their decisions and actions in very challenging circumstances. Where a concern is raised about a registered professional, it will always be considered on the specific facts of the case, taking into account the factors relevant to the environment in which the professional is working. We would also take account of any relevant information about resource, guidelines or protocols in place at the time”*<sup>9</sup>. As a further illustration of the recognition of the difficulties involved in providing care during the pandemic, the European ADHD Guideline Group published specific guidance<sup>9</sup> that includes how to manage ADHD when COVID-19 limits the ability to carry out the usual physical monitoring required as part of the treatment. In summary, clinicians are advised to provide as good and safe a service as is possible within the limits imposed by COVID-19 and to document and justify any deviations from what would have been considered usual practice prior to the pandemic.

With COVID-19 infection and death rates declining and restrictions starting to be lifted in the UK, CAMHS services are now looking at how best to operate safely and still meet the needs of CYP in what has been termed the “new normal”. The lockdown restrictions have caused distress to many CYP especially those with neurodevelopmental disorders<sup>10</sup>. A surge in demand for CAMHS is expected as the pent up distress starts to become released. The need to continue some degree of social distancing suggests that a quick return to full onsite and in-person service delivery is unlikely. Therefore some of the benefits of remote clinical delivery would need to be maintained. Services would need to have a triage system to enable the children with the most need for face to face assessment to be seen in

<sup>8</sup> <https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus>

<sup>9</sup> [https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642\(20\)30110-3/fulltext](https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(20)30110-3/fulltext)

<sup>10</sup> [https://emergingminds.org.uk/wp-content/uploads/2020/05/Co-SPACE-report-02\\_03-05-20.pdf](https://emergingminds.org.uk/wp-content/uploads/2020/05/Co-SPACE-report-02_03-05-20.pdf)

person within the limited clinical window available. In addition to CYP presenting with mental health crisis, others whose elective assessments have been held back due to COVID-19 may also need to be prioritised. The latter group include CYP whose assessment for ASD has been delayed because of the need for face to face meeting to complete ADOS. As CYP are primary users of CAMHS, it is important for services to seek their views in planning return to the “new normal”. The CYP who need face to face appointments may feel more reassured if they know that other CYP contributed to the CAMHS’ plan for resuming in-person care.

A central feature of ethical challenges is that they have no obvious right or wrong answers. If they do, they would cease to be dilemmas. In this difficult and confusing COVID-19 era, the more helpful approaches to addressing ethical dilemmas usually come from harnessing the views of stakeholders, referencing relevant professional, ethical and legal guidelines, and if necessary, discussing the situation with designated in-house and or external professional advisers. The outcome of these deliberations may still be neither right nor wrong but it is likely to be more ethically, legally, and morally balanced.

Clinicians may need to remind themselves that while COVID-19 has been the most distressing experience for most people alive today, previous generations went through similar or worse pandemics and individuals and societies recovered.<sup>11</sup> Similarly, the present society will get over COVID-19 and it will eventually become a point in history as previous pandemics. Reminding oneself of this point and sharing it with the CYP and families that use CAMHS could help to engender hope where despair could otherwise prevail.

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<sup>11</sup> Martini, M., Gazzaniga, V., Bragazzi, N. L., & Barberis, I. (2019). The Spanish Influenza Pandemic: a lesson from history 100 years after 1918. *Journal of preventive medicine and hygiene*, 60(1), E64.

**Harrington Essay Prize****First essay of the two joint winning entries****Razan Halawa****How to improve child and adolescent wellbeing: Lessons and Reflections from the Palestinian Experience**

What would I do to improve child and adolescent wellbeing? This is a question I have been asking myself since arriving at the UK three years ago to pursue a career in Child and Adolescent Psychiatry. What I did not realize initially is that I held the roadmap to the answer with me all along.

I was born and raised in Palestine, a country under occupation and ongoing oppression. There are generations of trauma encased within the Palestinian Community. For most families, the political and socioeconomic climate renders life challenging <sup>(1)</sup>. Yet, Palestinian children and teenagers display a high degree of resilience. They have a unique and inspiring attitude to life. Through observation, reflection and exploration of the literature, I have sought to understand what contributes to the resilience of the Palestinian people. On this personal journey, I identified key themes which build personal resilience and community solidarity. I suggest that these themes have the potential to transform the mental wellbeing of young people in the UK.

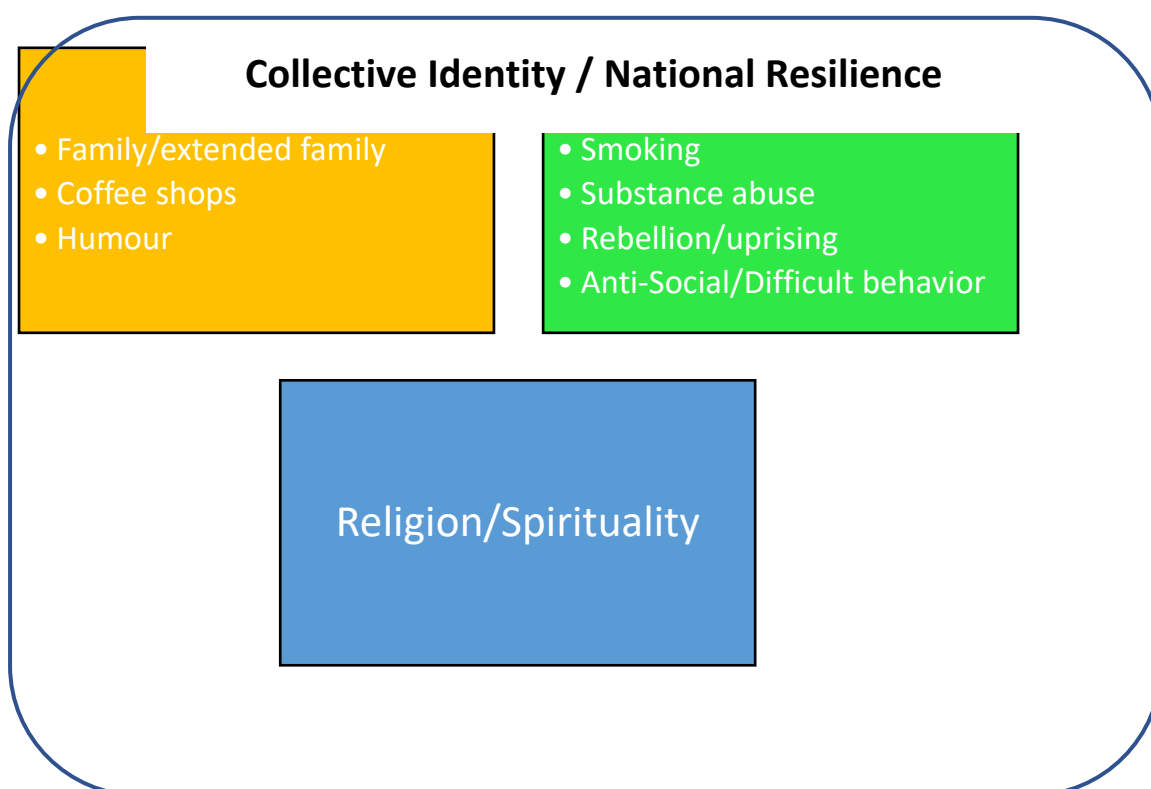
Of note, I am not suggesting that Palestinians have no mental health needs. On the contrary, there are multiple challenges and a severe shortage of mental health resources <sup>(2)</sup>. However, current professional dialogues and available literature tend to be unidirectional, focusing only on pathology, such as challenging behaviour and PTSD. I want to bring to attention people's stories, values, and strengths.

One important theme stood out throughout my journey: people in Palestine share a strong sense of identity. This collective identity is portrayed by 3 core Palestinian narratives and values which shape people's lives as described in a study published in 2017 by Atallah <sup>(3)</sup>. First, "Moqawama" which means resistance to occupation. It is not only a value but a Palestinian way of life; resisting through mere existence, pursuing academic development, and supporting local communities. Second, "Sumud" which means persistence throughout adversity. To every Palestinian, adversity is a known and expected part of life, and could at any point knock at one's door, consequently, a lot of strength and pride is portrayed when facing it "the Palestinian way". This negates the narrative of "why me" and replaces it with "this is part of life, it could have been much worse". This was a surprise for me; it wasn't until I left home and experienced different ways of living that I realised that what was a normal and expected part of life for us as Palestinians seemed grave and significant to others. The third value is "Al-Awda" and is related to going back to our roots. 5 Million Palestinians were displaced from their homes as a result of the conflict since 1948 and most of them left with nothing more than their house keys in the hope of a quick return <sup>(4)</sup>. This became the ultimate dream of every displaced Palestinian

and is seen as an inevitable truth, I remember speaking to an elderly Palestinian woman about the key necklace she was wearing. She told a tale of pain and loss but spoke of true certainty that she still wears it everyday waiting to be back.

This aforementioned collective identity creates an environment that strengthens Palestinian people's resilience. It sends out a strong message passed between generations where remembering becomes a necessity and a political statement. This has been observed and discussed in similar other 'conflict zones'<sup>(5)</sup>. It also reinforces other individual factors that are cultivated and strengthened in Palestinian children since the moment they are born as described in Figure 1. This includes several factors, some highly cognitive ones such as selective perception and cognitive reframing of previous and present traumatic experiences. Others such as religion, social factors and other behaviours<sup>(7)</sup>. I will discuss social and community factors in more detail in the following paragraph.

**Figure 1: Factors affecting Resilience, adapted with modification from Kumpfer 1999.**



As the saying goes, it takes a village to raise a child. Palestinian communities share strong ties both familial and local within neighbourhoods, villages and cities. This creates a strong supportive network and a sense of solidarity<sup>(3,6)</sup>. In the event of an escalation of the political situation, imprisonment or loss of a family member, Palestinian families and communities tend to come together and support each other. There are many examples of this but one comes to mind from my own experience during the second intifada 'uprising' in 2002. I was around 12 years old. My city Nablus was under siege and curfew. There was a real risk of being shot if one tries to leave the house and therefore, it was unsafe for students to go to school and huge concerns arose about the possibility of missing the academic year. This led to a community initiative called the community school. A large building in each



neighbourhood was identified, families in that neighbourhood donated used school books and teachers living in the neighbourhood volunteered to teach, families were asked to send their children with a chair for them to sit on. Not only had this worked very well in ensuring we didn't miss out on our education which is of great importance to every Palestinian. But it also provided a way of coping together and took the focus away from the war.

How does resilience in Palestine relate to child and adolescent mental health in the UK? Through my reflection on life in Palestine and my experience working in an inpatient adolescent mental health unit in the UK, where I have met young people with a wide range of mental health difficulties, stories and backgrounds. I have been able to draw out lessons for preventing and treating mental health problems whose relevance could transcend cultural setting.

First step should be directed at attending to young people's basic needs according to Maslow's hierarchy of needs <sup>(8)</sup>. This includes a safe home, enough food on the table, a loving family. This may seem obvious but the majority of young people's struggles stem from a disruption in these needs and lack of containment. This is also in line with the findings of the ACE study <sup>(9)</sup>. In Palestine, according to a study conducted in 2003 that interviewed around 450 Palestinian parents in Gaza and West Bank, the majority of parents identified that the responsibility to provide for their children lies with them despite 43% of them not having the means to do it <sup>(10)</sup>. Due to the dire circumstances and having no control over the political and resulting socioeconomic situation, offspring become the family's way of sustaining itself and its only chance for survival. Consequently, parents would go above and beyond to provide for their offspring and ensure receipt of basic needs and especially education which is seen as the only ticket for a better life <sup>(10)</sup>. This co-dependent relationship between parents and offspring is one of the factors that maintain clear responsibilities and roles in relation to basic needs for mutual survival where there's no other choice and the family becomes one unit working to sustain itself through its different members at different times.

As a practical step in the UK, I think it's vital to prioritise the role of social work in ensuring these needs are met and supporting families that are struggling to provide for their young ones.

Second step is to focus on family and support systems. This includes a major role of family and systemic therapy, schools and professionals to support families and young people. This is a community and professional responsibility and this is where we should start thinking about the narratives that we live by as a nation and what messages and values are of importance.

The sense of community solidarity I experienced in Palestine when my city Nablus was under siege inspired in me a sense of strength, pride and hope that we shall overcome any obstacle as long as we come together. We can strengthen community ties here in a similar way through community and school initiatives. I have started to see some signs of that during the current COVID-19 crisis; neighbourhoods and communities are coming together trying to support people who are unable to attend to their own or families' needs. As a future child and adolescent psychiatrist I intend to take an active role in leading some of these initiatives and supporting systems and organizations that facilitate that.



Third, this is more targeted at the individual level. Adversity is an inevitable part of life but what we can focus on is helping young people on their journey to deal with the distress it causes, strengthen their resolve and allow for growth and positive adaptation following it. This could be achieved through identifying and strengthening acts of resistance which are sometimes overlooked. These acts stem from a place of strength, and focus on what is truly important for the young person. UK culture does not often have a place for pain and sees it as a personal failure, I believe there's much to learn from the Palestinian concept of 'sumud' as it brings out a positive connotation to pain, instead of invoking a sense of shame. A practical step towards addressing that would be through working with the young person (eg through art therapy or drama therapy) to enable them to identify their own sources of strength.

In all settings, child and adolescent mental health faces multiple challenges. My reflection on Palestine reveals community and individual factors for resilience and identifies possible lessons from the Palestinian experience. Internationally, these tools have the potential to inform strategies for young people's mental health.

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## ***Being an operational and clinical lead during a pandemic***

**Guy Northover**

Mixing operational management and clinical leadership whilst being a front-line clinician is a daunting thing to do at the best of times, but during a pandemic can seem even more overwhelming. I am writing this to convince everyone that rather than being more daunting, doing such mixed jobs is far more rewarding during a period of crisis, not from a workload perspective but certainly in terms of impact and population benefit.

Being the trusts Lead Clinical Director<sup>12</sup> I immediately took responsibility for the ethics response to COVID-19 resulting in an early, active and effective ethics committee. We considered issues such as providing clinical care without access to effective PPE and ethical dilemmas such as use of seclusion in COVID positive patients and other complexities of the Mental Health Act, clozapine monitoring etc.

I am responsible for clinical leadership<sup>13</sup> within the trust Quality Improvement programme and whilst, during the pandemic, not all services were able to continue with effective QI methodology, my leadership has promoted those areas which have. I have supported numerous QI projects implemented to mitigate COVID-19 challenges where PDSA cycles have continued, where front line clinicians ideas are those that have been taken forward and where the data has continued to be collected to demonstrate the improvement successes. I have been able to ensure that the trust's response to the pandemic has not been an entirely top down control and command approach.

Digital has been a huge revelation throughout the pandemic but digital must not be implemented 'because it is digital' but done where it will truly make a clinical difference in a safe and effective way. As Chief Clinical Information Officer (CCIO<sup>14</sup>) I have influenced the digital response to COVID-19, we are truly able to work from home with a clinically led balance of home vs office working based on service user need and staff morale: not based on IT needs or micromanagement. Videoconferencing for teams and for client contact has been a huge success by ensuring its roll out is clinician led with multiple videoconferencing platform options, effective training and support and with videoconferencing being seen by the trust as an additional option not the only or best option.

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<sup>12</sup> Trust Lead Clinical Director: this is an operational role where I am operationally responsible for the 6 clinical directors across the organisation, covering all mental health and community physical health services and wards. I attend all the executive meetings and provide the direct clinical challenge to the exec on all trust wide projects.

<sup>13</sup> Clinical Lead for Trust Quality Improvement Programme: although less active in this role at present I was the clinical representation on the QI programme board, ensuring that the programme remained focused on quality and effectiveness and not just efficiency. I led work around clinical engagement with the programme and continue to engage with teams about to start their first QI journey.

<sup>14</sup> Chief Clinical Information Officer: this is a clinical role for a senior clinician to take leadership responsibilities whilst sitting in between the IT teams and the front line clinical teams, the role ensures that the appropriate clinical governance processes are in place around the health informatic teams, that clinical concerns and areas of improvement are heard by the IT team and the challenges and limitations of what the IT teams can do are understood by the front line clinicians.

My trust roles have allowed me to develop national influence<sup>15</sup> and I now co-chair the data subgroup of the Tier 4 clinical reference group. This means I have had the opportunity to review, comment on and alter a whole array of national guidance, released in response to COVID-19. Within the Faculty, taking up the role of Quality Improvement Lead also allows me to use my expertise in ways that are wider and far further reaching.

Vitally important to me is my clinical work<sup>16</sup>, maintaining this through the pandemic, supporting the team's uptake of digital and remaining confident around providing therapeutic care has been hugely rewarding. I truly believe that every step I have taken into leadership and management has made me a more effective, compassionate and skilled clinician.

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<sup>15</sup> National Clinical Lead Getting It Right First Time for Children and Young People Crisis and Urgent Care Services: a project to identify variations in care using nationally available data followed by deep dive visits to NHS and independent providers identifying which variation is warranted and which is unwarranted and requires an improvement programme.

<sup>16</sup> 2.5 sessions/week Consultant in Berkshire Children and Young People Early Intervention In Psychosis Team

## ***Families under Pressure: Animated parenting tips for struggling households***

***Andrea Danese***

Many professionals have been concerned that young people and families struggled to access CAMHS services during the COVID-19 lockdown and may face long waiting list in its aftermath. To support parents under these challenging circumstances, Professors Andrea Danese (CAP Faculty Academic Secretary) and Edmund Sonuga-Barke from King's College London have prepared simple tips on how to manage behavioural and emotional symptoms in their children - the Families under Pressure project, funded by the Maudsley Charity. The material is delivered through engaging animations crafted by the production company TOAD London and narrated by famous parents including Olivia Colman, Rob Brydon, Holly Willoughby, Danny Dyer, Sharon Horgan, Dame Jessica Ennis-Hill, Romesh Ranganathan, Shappi Khorsandi, Alex Jones, David Harewood, Julie Hesmondhalgh and Sandi Toksvig. The material is freely available from the Maudsley Charity website

[Families under pressure](#)

It is also available on King's College London YouTube Channel

<https://www.youtube.com/playlist?list=PLun2jODy9M2fz4KuSfEh4DLqEO0M-Klyd>

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## ***Thank you to the people who have been supporting healthcare professionals***

**Ruth Marshall**

Many junior doctors, including psychiatrists have been redeployed during the pandemic. Other psychiatrists have been adapting to working in new ways; video calls from home or the office, socially distanced face to face appointments or outpatient appointments in PPE. Inpatient psychiatrists have been working hard to develop safe ways of supporting children and young people whose mental health needs require inpatient admissions.

The general public have tried in so many ways to support the healthcare staff; we have all felt encouraged by the messages informing us that food has been delivered, or that we can shop at times protected for key workers. So many people want to help at this time, and some people have offered truly valuable support by donating their time and skills to making scrubs.

Ensuring that infection is not carried from the hospital ward to the community is a key challenge, and the children's unit (Galaxy House) in Royal Manchester Children's Hospital are very grateful to the Pink Scrub Sewers from the Whalley Range/Chorlton area of Manchester.



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## ***Values, behavioural activation and acceptance and commitment in COVID-19***

**Leo Kroll**

Values, conflict in values, and behaviour have risen to the top during COVID-19, and it will be interesting to see what next shows up. Wellbeing of staff and offers of support seem more valued now than before COVID-19. The narrative within society and NHS culture has changed, hopefully permanently, to less of command and control and financial probity, and more towards care, compassion and a focus on people. Tensions between capitalist narratives and those of care for people and the environment continue naturally.

Within all this sea of value conflicts, parents, children, and young people continue to navigate life individually and collectively. Some will flourish and some have increasing difficulties. Social disadvantage and other factors are almost certainly related to increased risk of difficulties.

For me, in addition to leading on values-based practice for the college, my research is focused on behavioural activation and acceptance and commitment therapy, which have close contextual links. Together with Bernadka Dubicka, I have put together a CPD module (in development) on behavioural activation and how it may be of use during COVID-19, particularly focusing on values and values realignment, together with the need to structure daytime behaviours, disengage flexibly from previous goals, and re-engage flexibly with new goals aligned to values.

Andrew Beck the president elect of the BABCP has also published a good and timely article on behavioural activation on the ACAMH website

[Using behavioural activation to improve families mental health in lockdown](#)

In addition, many of the resources that are now freely available have at their heart principles and practices found in acceptance and commitment and behavioural activation therapy. The Career Psychologist published a useful digest of these.

[Practical ideas to survive and thrive in the age of coronavirus](#)

For me, and I hope others, these types of strategies are pertinent for all, both those with difficulties, and those who are flourishing.

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## ***Schwartz Round Blog***

**Rory Conn**

The delivery of high quality, compassionate healthcare is reliant on good communication, between staff, patients and families, and also between clinical and non-clinical professional groups.

We take for granted perhaps the importance of body language, eye contact and physical contact – being present with one another - these are the basis for the ‘small acts of kindness’ which Kenneth Schwartz described in his own care - the nurse who holds the patient’s hand, the passing of a cup of tea, the comforting smile, or the hug of condolence.

During the COVID pandemic, clinical requirements of enforced social distancing and use of Professional Protective Equipment (PPE) have made these ordinary, but highly meaningful interactions impossible in some clinical settings. The pandemic has also meant that bringing staff together for

structured, regular reflective conversations over a shared lunch (the model of the Schwartz Round) has also sadly been put on hold.

Our joint rounds in Devon Partnership Trust and the Royal Devon and Exeter were suspended in March. Their absence was felt acutely by staff and facilitators alike. We resolved to embrace new technology and pilot a “remote” round, using a Webinar platform, via which 3 panellists and the facilitators would all be audible and visible, with attendees muted but able to contribute to the discussion via a live text feed. We called the round: *Tales of COVID-19: Experiences of healthcare staff during a pandemic*

Potential benefits we anticipated included being able to reach a wider audience than normal, and therefore being more inclusive. Most Schwartz Rounds in our organisations attract around 70 attendees. At its peak we had 189 staff logged in and interacting, from across Devon. We wondered whether people would use the text comment function. After a slow start, this exploded with a total of 38 questions and observations submitted, many of which were then read out and reflected on by the facilitators. A “normal” round might only allow for 5-10 comments from the ‘floor’.

An additional benefit was the potential to record the round. Contributors names were omitted in discussion to preserve confidentiality. We plan to publish the recorded session so that more staff can benefit from the rich discussions.

Themes which emerged in our round were wide ranging. We held in mind that it was possible that individuals might experience varying emotional responses, day by day, moment by moment, from feelings of detachment to deep emotional distress, and that all staff will have different personal and professional circumstances which influence how they have been affected.

Some were able to speak of the sense of excitement which had come, particularly at first, from the adrenaline fuelled prospect of emergency measures. Some thrive, of course, in such situations. More common was the experience of anticipatory anxiety that came with multiple uncertainties of process and content. Many people work best with predictable routine and these were hugely disrupted in the upheaval.

Staff members reported finding it difficult to care for themselves, such has been the weight of responsibility to look after others, and keep friends and family informed – those at the frontline seem to be looked to for “information” and predictions of what is to come. We thought about means of finding time away from news reports and constant reminders of the unfolding situation.

Many related to the concept of ‘Moral Injury’, an increasingly recognised psychological theory which describes the profound emotional disquiet we can all feel when our actions do not reflect our moral values. There was sadness that the service provided has at times felt “2nd class” and an increasing awareness of growing waiting lists which will inevitably lead to greater work pressures on resumption of more ‘normal’ clinical patterns.

A grieving process was described, not only for patients lost, but for established ways of working which have by necessity been set aside – e.g. the lunchbreak gathering in a staffroom.



For those needing to stay at home to shield, this had come at a cost. A sense of disconnectedness from the wider team, the guilt of not being able to “contribute” as they would have liked, the disempowerment inherent in being displaced.

Some have been redeployed to new working environments, asked to learn new ways of working at phenomenal speed. Again, the impact of this is wide ranging. For one person this might feel like an invigorating process or opportunity for change, for another a traumatic displacement to unfamiliar surroundings. There were reflections on the benefits of understanding better how other teams operate, and the interconnected roles of other professionals.

The use of new technology during COVID-19 has allowed clinical consultations to occur with patients via videolink. Some spoke of their delight that such innovations (which may have otherwise taken years to be implemented) may now become the “new normal”, allowing some patients to access support and interventions with less disruption, in particular those with physical disabilities. Others experienced working from home as an intrusion – the inviting in of colleagues and patients into their personal lives and environments an unwelcome development, as boundaries between work and ‘life’ become blurred.

Staff spoke of the huge upheavals in personal and professional lives that have come from new ways of working and being. Strikingly, we thought about how the hospital, ordinarily a place of safety and refuge, has become for our patients a potentially threatening or dangerous environment. Additionally, some staff now experience coming to work fearful for their own safety, and that of their family members when they return home.

Conversations about life and death are now more routine, some observed. This was considered by many to be a positive – opening up discussions that previously may have been deferred or ignored all together. We are, it seems, in a more secure place to think about what really matters in life, and in healthcare.

Overall, this was felt by the facilitators and panellists to have been a positive novel experience and we would encourage other Schwartz organisations to give this approach a go.

Now, at a time when healthcare staff most need to “come together” the restrictions imposed upon us mean we are unable (physically at least) to do so. The innovation of a remote Schwartz Round allowed for the sense of community which comes from shared narratives not to be lost.

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## ***An inner city CAMHS clinic during COVID***

**Dr Bloster**

'Your patient has just rung to say she hasn't had your Webex link' our patient team administrator writes. 'Double F\*\*\*!' I mutter to myself, quickly clicking mute to avoid being heard. I see a sitting room filled with newspapers and objects and a mantelpiece crammed with items, a blurry figure floats within. Is it possible to blur yourself and keep the background still, I wonder? A hum and an a screech begins. I get onto our computer system and find the patient's phone number. Twenty sweaty minutes have passed and both I and the patient are tense and stressed.

Actually, I have found it moving, troubling and sad having access to patients' homes in the last few weeks. I have seen parents exhausted and weeping, looking after children with neurodevelopmental conditions. I have told people not to despair and that things will get better. I have seen people frightened of losing their jobs, struggling to work around their children. My colleagues at the online consultants' meeting look pale and worn. I am shocked by how tired they seem and by some of the bad hair styles.

Sometimes I am admitted by technology to dark rooms where I can hardly see the figures within. Children are elusive, slipping from chairs, hiding under duvets and one seeming to float ethereally on the screen like an astronaut, an effect that she informed me can be achieved by moving the iPad around. It is occasionally possible to see siblings and grandparents self-isolating together- the lockdown has brought a new meaning to the family as a place of last resort. We are all in our caves together, trying to get along.

The Team are trying to manage both the recent horror of the virus and the worry over racism and deaths of black and ethnic minority friends, family and colleagues. Everyone is doing their best and we are all very tired from long days on the computer. In many ways we are closer than ever. Tempers fray easily. Sometimes, with the hopelessness of wanting to be young again, I wish we could all just get back to work like it was before.

In my worse moments, when I am at work, I resent my colleagues for not being able to come to work because they are self-isolating and then I feel bad about it. I hate the weird social distancing for children in schools and I am sad about the situation for many of the teenagers I see. However, I am aware 'love laughs at locksmiths' and that many of them are meeting up in local parks for illicit snogging and shagging.

Our own teens are drifting around in the glorious summer evenings heaven knows where. Of course I worry, but I know that life is risky, always has been. I'm glad I'm not making the decision about whether to relax the lockdown. I'm just getting overweight, grey and stressed sitting at the computer for hours at a time and saying 'Can you hear me? Is anybody there? I think you must be muted'.

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## ***Fiction, Childhood and Lockdown***

**Jane Whittaker**

### **Introduction**

It is pretty redundant to say we have all been through a lot in different ways over the past months. For those confined to home working, shielded or stranded much was made of setting lofty goals; learning a language, a musical instrument or cleaning out the garage. In fact many of us found ourselves watching our body hair grow, living in pyjamas and abandoning ironing.

One of the recurring lofty goals touted was to tackle what Beejay Silcox called the “shelf of reproach”, containing all those books that were bought and never quite read. My literary *bête noire* is *Romola* by George Eliot, as I write I am about a third of the way through and struggling. There has also been a lot written about plague fiction including classics like Camus and his *The Plague*, Defoe and his *Journal of a Plague Year*. There has been an occasional mention of *The Decameron* by Boccaccio. My book group read *Year of Wonders* by Geraldine Brooks last year. At the time it was an interesting historical novel inspired by the story of Eyam in Derbyshire, the village that elected to close itself off from the rest of the world when the 1660’s plague arrived.

### **Why read fiction? Haven’t we enough to do!?**

A background of working with children with eating disorders and their families inevitably means I lapse into food-contaminated metaphors. For me reading is a necessity, not an indulgence and fiction is like food. Sometimes you need something robust and substantial - steak and chips; sometimes something worthy - salad & steamed fish; and sometimes you just need candy floss.

Reading fiction is distraction, absorption, a short holiday and even educational if you buy into (the oxymoron of) historical fiction. The cliché is that fiction allows us to enter the lived experience of others and it is a cliché that every cliché has a grain of truth. And perhaps it is no accident that many novels have been written by doctors (and other health professionals) and they write about the predicaments experienced by their patients. We have our noses rubbed right into the grubbiest bits of being a human being. The current crisis is no different. And of course, psychiatry is one of the specialities that has always encouraged its students to read fiction.

Professor Femi Oyeboode has written extensively and eloquently about the importance of fiction for psychiatrists and has edited a whole book on the subject. He cites writers like Chekhov (also a doctor) for insights into the human condition. I have tried over the years (with varying degrees of success) to persuade trainees to read Goya’s *Diary of a Madman*, and Waugh’s *Diary of Gilbert Pinfold*, both astonishingly insightful accounts of the characters’ experienced descent into psychosis. Jean Paul Sartre’s *Nausea*, contains a haunting account of an episode of depersonalisation even if the philosophy is a bit of struggle.

**What about childhood?**

As child and adolescent psychiatrists we have the double whammy of grappling with developing minds that are concurrently troubled minds. And we rely heavily on reports from observers. We have lots of experience of working with an absence of reported subjective experience be it the silent adolescent behind a hair curtain or the fizzing eight year old with hyperkinesia and a touch of autistic traits. But we can certainly do a lot of inferring. We may even find out later when our patients decide to tell us.

Our understanding of what childhood and adolescence even is has changed, and will no doubt continue to change. Over the centuries society has moved from children and adolescents being the property of their parents, part of the workforce and miniature adults. We talk now of increased child rights and recognition of individuality, but also increased and extended dependency.

Realistically, childhood and adolescence now extends into the late teens and early twenties. Our children and adolescents are revered and protected, reviled and dismissed. They are viewed as infuriating, utterly self-absorbed and passionately socially concerned – all within the same adolescent. We are all familiar with the vegan environmental activist shouting about the benefits of no air travel at home with furloughed mum, or adolescents in parks sharing a spliff whilst both wearing face masks.

I suspect we all have our own remembered examples of toe curling adolescent idiocy and maybe some less excruciating shining successes. Our advantage in our work is that we have all experienced childhood and presumably could think about the experience as experienced if we were to imaginatively engage with our patient's inner worlds or create fiction? But remembering the past is always through the prism of the present and all the experiences that have brought us to that present.

The novel is a relatively young art form and children have taken on different roles in them, but almost always viewed from the perspective of their impact on adults. Dickens fully exploits the different child archetypes. They are little angels (Nell in *Little Nell*), poor victims of terrible circumstances (the children in the Ghost's cloak in *A Christmas Carol*), abused (Smike in *Nicholas Nickleby*) or dangerous disruptors (Fagin's children in *Oliver Twist*). We recognise the stereotype because they have been with us for two hundred years, probably before. They are still with us in more modern novels. Think of Doris Lessing's *The Fifth Child* as an example of a terrifying child. Children can be the heroes in children's fiction, rarely in adult novels.

Well written fiction about childhood is rare. Work in an authentic child's voice is even rarer and has a shocking intensity. Roddy Doyle's *Paddy Clarke Ha Ha Ha*'s description of his character sat at the top of the stairs listening to his parents' row escalating into violence should be compulsory reading for all child psychiatrists. Nina Stibbe's *Paradise Lodge* is a novel of growing up and trying to make sense of a world where a parentified adolescent has to prop up a beloved but chaotic mum in a world where adults are truly badly behaved. Kit de Waal's novel *My Name is Leon* offers a stunning insight into a child living with the fallout from parental mental illness and the cruelty of a care system that separates siblings. However the spoiler alert is that the happy ending may well grate on those of us who have worked alongside children from looked after backgrounds. Anyone who has read *Room* by Emma Donoghue and not been moved by it probably should not be doing child psychiatry.

**What about plague, fiction & children and adolescents?**

Camus' *Plague* was published in 1947. It is worth a read if you have not tried it yet and if you can bear it. It has also been subject to a recent College podcast (see the College website for details). The cast of characters are instantly recognisable three months on from lockdown; the heroic doctors, prevaricating politicians, profiteers (think bottles of hand sanitiser) and a community in lockdown. Separation, isolation death and destroyed livelihoods are all there. A child, son of one of the minor characters dies from the plague, horribly and graphically. But the plot device is about the impact on the child's family and the personality change effected on the child's father because of the bereavement. The key climax to the book is the death of the doctor's close friend who explains his philosophy (and Camus') on his deathbed.

Defoe's *Journal of a Plague Year* also references children in the context of their deaths and mode of dying but his focus is, like Camus, the impact on their parents or concurrent deaths of parent. He does reference the plight of children left parentless and the increased death rate in mothers dying in "childbed" perhaps presaging the rationale for our current advice to pregnant health workers. Written as a form of diary reportage (although decades after the plague) it has a clinical detachment.

Boccaccio wrote *The Decameron* in the mid-14th century. Renaissance Italians were intimately familiar with plague. A group of wealthy young Florentines get together in a country house to sit out the plague and tell stories. Given life expectancy and the definition of an adult in their times it is likely to that they were in their late teens and early adulthood. Think first year undergraduates or thereabouts. Certainly the bawdy content of the stories suggests that they have quite a party whilst presumably breaching the 14th century equivalent of social distancing and lockdown. Perhaps they were just following their instincts.

So our classic plague fiction reads like fiction for adults about adults with children as secondary. Children and adolescents generally only appear in the context of their impact, especially their deaths, on adults. Perhaps this mirrors our own experience of wondering what to tell children about the epidemic and how to explain it. Are they are regarded as minor characters in this particular story rather than core participants. We are regularly reminded that, unlike other plagues, they are less likely to become seriously ill or die than their grandparents. And we are being exhorted to get them back to school; a reasonable acknowledgement of the importance of social and educational wellbeing or canaries going down a mine in the rush to re-start our economy?

The history of pandemics teaches us that whilst the causative organism knows no boundaries that the most vulnerable experience the worst effects and greatest adverse impact and subsections of the population will shoulder the bulk of the blame. A fifth of our children live in poverty, the lack of schooling differentially impacts on those without access to online resources and articulate, educated parents. Lots of our families do not even own a book. Social and emotional development is being compromised by lack of peer groups at best and exposure to damaging, even dangerous home environments at worst. Children and adolescents may well be least affected physically, but there is a real possibility that (along with older people) they are most affected emotionally and psychologically. And their voices are least heard or written about.

**Conclusion**

Beeyjay Silcox in the Times Literary Supplement podcast of 30th April this year described not being able to write the beginning of a story about the COVID-19 pandemic because she could not see the end. For our children and young people is the pandemic going to be a defining event like 9/11 was for many of us? Or will it be just something that affected old people and made parents a bit harder to live with for a while. The ending for children and adolescents is likely to be years away. And will there be a place in fiction or elsewhere for their voices to be heard? Hopefully we will be reading attentively.

**Reading List**

Boccaccio - *The Decameron*

Brookes, Geraldine - *Year of Wonders*

Camus, Albert - *The Plague*

Checkov - *The Ward*

Dickens, Charles - *Oliver Twist, Little Nell, Nicholas Nickleby, A Christmas Carol*

Defoe, Daniel - *Journal of a Plague Year*

Donoghue, Emma - *Room*

Doyle, Roddy - *Paddy Clarke Ha Ha Ha*

Eliot, George – *Romola*

Goya - *Diary of a Madman*

Lessing, Doris - *The Fifth Child*

Sartre, Jean Paul - *Nausea*

Stibbe, Nina - *Paradise Lodge*

de Waal, Kit - *My Name is Leon*

Waugh, Evelyn - *The Ordeal of Gilbert Pinfold*

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***Invisible youth at risk during the COVID-19 Pandemic<sup>17</sup>***

**Alison Flynn and Gabrielle Pendlebury**

Adolescents who present with complex forensic mental health needs are particularly unlikely to engage, even without the current restrictions arising from COVID-19, and can be overlooked as a result. The Forensic Child and Adolescent Mental Health Service (FCAMHS) is aware that this is a highly vulnerable group, often experiencing early trauma, repeated loss, attachment issues, learning difficulties, mental health problems and social inequality. The pandemic has reduced access to education and other agencies that previously provided support and structure, thus exacerbating vulnerabilities and removing protective factors.

<sup>17</sup> Hales, H et al. Invisible youth at risk during the COVID-19 pandemic. The Lancet. Vol 7 July 2020

Isolated young people with social communication, cognitive or emotional difficulties are at increased risk of exploitation by others. Risks relevant to this group go beyond the risk of offending and risk to others and include being groomed into gang-related activities (including County Lines and other criminal exploitation).

A recent serious case review<sup>18</sup> highlights the plight of 14-year-old Jaden Moodie who was murdered in January 2019. The review was of relevance to our service, as we are both clinicians in a community forensic adolescent outreach team (FCAMHS) and are often faced with young people being criminally exploited.

Jaden began getting into trouble in the community and the family were threatened in an attempt to recoup accumulated debts. As a result of this the family relocated to Waltham Forest. However, Jaden remained out of education, a significant risk for those vulnerable to criminal exploitation and was found in Bournemouth in the company of an adult selling drugs. There were delays in housing and education applications and reachable moments were missed. Sadly, Jaden was murdered a short time later.

The review makes the following recommendations for work with these young people; a national system for responding to children who are arrested and detained away from their home areas, every area needs some form of 'rescue and response' system and finding ways of working with those who have had difficult experiences of help and authority.

We just wanted to raise this review so that clinicians have this risk in their minds when they are assessing adolescents at this time.

The review did not identify specific instances of racism. Yet the family's lived experience was that racism formed some part of Jaden's trajectory. We would also like to express our commitment to addressing the structural and systemic racism impacting the lives of many young people and families referred to our service. As a team, we place great importance on understanding harmful behaviour in context and this includes the impact of structural racism and inter-generational trauma on early life, psychological and emotional development, attachment and relational trauma.

We are aware that the pain raised by injustices highlighted in the Black Lives Matter movement and how the disproportionate impact of COVID-19 on these communities has impacted on many young people and families referred to FCAMHS, as well as many colleagues in professional networks.

We are committed to addressing ways in which our team and professional networks may indirectly maintain structural and systemic racism. As a consultation service we pledge to play our part in creating safe spaces for these conversations to happen, so that we can take collective action.

The Forensic Child and Adolescent Mental Health Service at the Portman Clinic is one of 13 services across the country that provides advice, consultation and assessment and treatment of youth at risk

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<sup>18</sup> [https://www.walthamforest.gov.uk/sites/default/files/WFSCB%20-%20SCR%20Child%20C%20May%20final\\_.pdf](https://www.walthamforest.gov.uk/sites/default/files/WFSCB%20-%20SCR%20Child%20C%20May%20final_.pdf) (accessed 9 June 2020)

of offending or high-risk behaviours. A clinician is available 9-5 Monday to Friday and can offer advice or signposting, if not appropriate catchment by emailing [portman.fcams@nhs.net](mailto:portman.fcams@nhs.net) and requesting a call back.

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### ***Report from Trainee Representatives***



**Kiran Panesar and Omolade Abuah**

Hi everyone, we hope that you and your loved ones have all been keeping safe and well during this difficult time. This has been a challenging few months for a lot of people both personally and professionally and the current situation we are in is ever changing. We hope that you have all been able to get the support that you need during this time.

The Co-SPACE project run by Oxford University is trying to capture valuable data from parents, children and young people through COVID-19. They are tracking the mental health of school aged children and young people aged 4-16 years and are keen to recruit as many families as possible to the study. We thought this would be a good place to share what they have done so far and make you aware of the study.

An online survey is sent out and completed on a monthly basis by parents/carers and young people (if aged 11-16 years) throughout the pandemic. The findings will help identify what protects children and young people from deteriorating mental health over time, and at particular stress points. Findings will be shared directly with health and education services to inform the development and provision of effective support for children and families.

Key findings from the first 5000 participants include:

- Among our sample, nearly half the parents/carers thought that their child was concerned about family and friends catching the virus.
- Around a third of parents/carers reported that their child was worried about missing school.
- Work is the most frequent source of stress for parents, followed by their child's emotional wellbeing.
- Parents of children with special educational needs and neurodevelopmental disorders (SEN/ND) report higher levels of stress across all areas.

- While child behaviour is rarely a stressor for parents of non-SEN/ND children, it was frequently a stressor for parents of children with SEN/ND.
- Parents working outside the home report particular stress around work, followed by their child's wellbeing and education.
- 80% of those who were previously receiving support from services have had this stopped or postponed during the pandemic.
- Parents particularly want support around their child's emotional wellbeing, education and coming out of social isolation. 1 'Completion' of the survey is based on participants having completed items up to and including the pre-defined main outcome measure (the Strengths and Difficulties Questionnaire – parent reporting on child). 4
- Parents of children with SEN/ND would also like support around managing their child's behaviour.
- Parents/carers would value online written materials and videos, while parents with children with SEN/ND would also like online support from professionals.

The link below provides more information about the study and how you can get parents and young people involved.

[Co-Space Report-02](#)

Parents/carers can sign up and take part at any point:

[Co-Space survey](#)

We wanted to also mention about the upcoming trainee conference in November. As the College is now not holding any face to face conferences until next year, we are looking at alternative ways of holding our trainee conference in the virtual world – watch this space!

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## ***Working on call during the COVID-19 pandemic***

**Cosmina Cross**

The past couple of months have been the most exciting and confusing months in my career so far. I currently work in an adult forensic low secure unit and cover the regional child and adolescent on-call rota on a regular basis. I have a special interest in child and adolescent psychiatry and this experience is invaluable. I have been covering this rota for the past 3 years, on average 3 times a month.

As part of my day job I cover the adult on-call rota as first on-call. Despite national discussion on reduction of face-to-face activities to decrease rate of COVID-19 transmission, the adult on-call



activities have been mostly unchanged. I am expected to review patients in acute hospitals, emergency departments, Police custody, and place of safety or in their own homes in the community. We usually meet as a group: two psychiatrists, one or two approved mental health practitioners, sometimes a full ambulance crew and relatives prior to entering premises. We might enter patient's property and may encounter other relatives indoors, including children. We wear face masks and gloves. Most times patients report feeling concerned and scared – worried about catching the Coronavirus from us, or scared of masked people entering their homes. It is often difficult to keep 2 meters distance in small rooms. As healthcare professionals we feel exposed and guilty of inflicting more psychological distress on our vulnerable patients. The only silver lining is that there is no expectation for additional clerking by the on-call SHO on the same day, or out of hours.

By stark contrast, I find that the Child and Adolescent mental health services have quickly acted and collaborated with the local CAMHS and paediatric services to provide a much improved and streamlined service out of hours.

The agreements have produced clear guidance to processes and responsibilities out of hours. There is a Red-Amber-Green triage system that the doctors in Emergency Departments use to assess the acuity of CAMHS input and next steps. The CAMHS liaison services have expanded to cover weekends and bank holidays between 9am and 5pm. There is a clear pathway for the young people presenting to ED with overdoses or deliberate self-harm. The young people in the high risk group follow the paediatric admission route and have an urgent CAMHS assessment by the on-call psychiatrist and 1:1 nursing. However the medium/ low risk young people are followed up and assessed remotely by next working day. There is a new referral form for clinicians to complete and send to a generic nhs.net email address, as well as contact phone numbers printed on the referral form and the self-harm pathway.

Apart from the additional support from the liaison teams, the on-call consultant is always available for discussions and advice.

Prior to COVID-19 pandemic, on a weekend on-call I would have seen up to 6 young people for assessments across the main 2 hospitals in my area (approx. 30 miles apart). I would have started working at 9am and stopped late at night, sometimes finishing letters and notes the next working day. There was a less clear pathway and the support out of hours was limited to the advice from the on-call consultant and a limited crisis service called i2i covering part of the on-call patch. I would spend many hours during the following week ensuring documentation would reach the correct CAMHS team where the young people would need to be seen or referred. Additionally, I would spend even more time typing letters to GPs about the assessments. The anxiety of having missed something or not knowing that the young people will be adequately followed up prevented me at times from covering the on-call rota.

I warmly welcome the current changes to the out of hours working in CAMHS. I feel more supported and confident that no young person gets lost to follow-up. I hope that this will continue after the pandemic and the hard work done during this time will not be wasted.

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## Connecting in Crisis

**Kathryn Speedy, Fifi Phang**

*Kathryn Speedy is an ST4 in CAMHS in South Wales, and Fifi Phang is a CT3 in North Scotland. We met at the CAP Faculty winter meeting in January 2020 in London. Last week we arranged a video call to catch up and find out how each other was getting on amidst the Covid-19 pandemic...*



Fifi: Hi Kathryn, nice to see you again. It's been a while since we met at the CAP winter meeting.

Kathryn: Yes, things are quite different now! It feels like a long time ago, but at the same time it feels like only yesterday.

Fifi: I remember we were talking about leadership and telecommunication. This has now become even more relevant. I wonder how things have changed for you.

Kathryn: Well, we've not really seen many patients face to face where I work in CAMHS, except the most severe psychosis and those who are at high risk of suicide. Otherwise, we have been doing virtual appointments using Attend Anywhere and telephone reviews. It feels a little strange and it does make some assessments more difficult; but generally, reviews are quicker and some patients prefer it as they don't have to travel a long way to the clinic. I've also been seeing a lot more patients than usual, which has been good from a training perspective. How about you?

Fifi: I'm based in Liaison at the moment and although initially there was a lull, things are certainly picking up now. There seems to be more severe and complex cases with interesting delirium presentations. I've admitted patients not previously known to services and it feels that we've needed to use the Mental Health Act more.

Kathryn: We are definitely getting busier as well. I think people are finding the lockdown more difficult as time goes on. Children and young people are missing their friends, family and being able to go out.

It's also hard being at home all of the time if there are a lot of arguments in the household and parents are stressed. However, there have also been some children who have been much happier because they have social anxiety or were being bullied in school. But I guess they're the ones who are going to find it really hard when they have to go back to school.

Fifi: Some of our inpatients are not able to fully appreciate the social distancing measures. We've had to take precautions to shield some of our vulnerable patients too. Anyway, how's life at home for you and your family?

Kathryn: It's busy! The lockdown has not always been easy, but we try to focus on the positives! My husband is also a key worker, and we have a five and two-year-old, so it has been tricky juggling childcare, but we were lucky that the youngest's nursery has stayed open and the council set up a local childcare hub. My husband's shifts have all changed, which has made it harder to establish a routine for the kids, but we have done our best. I think that's all anyone can do! The kids have appreciated a slower pace of life on our days off. They've been playing in the paddling pool and in the garden, and we've found lots of lovely places to go walking that are local to us but we had never been to before! The nice weather has certainly helped.

Fifi: Sounds like you are getting to spend more time with your family. Our local CAMHS service has undergone a redesign recently with all staff equipped with laptops that allow work from home but other services are still finding its way around the new way of working. I have restarted my Liaison Clinic couple weeks ago via Attend Anywhere and also my Psychodynamic long case which was uncomfortable to start with. As for urgent assessments, we've been trying to do telephone reviews where possible; if not we need to don level 2 PPE (mask, apron, gloves) over our scrubs to see patients. Don't think consultants in psychiatry expected to wear scrubs again!

Kathryn: It's been hard at times to keep up with all the new and evolving guidelines for things like PPE, self-isolation and testing. I'm in so many different WhatsApp groups and although they've been a really useful way of communicating and keeping up with things, it can also feel that it's harder to switch off from everything, especially as I work LTFT. I've found running has really helped me.

Fifi: Definitely online communication has really taken off for us here too. I am representing twenty other junior doctors who are based in psychiatry, including FYs, GPSTs, Locum juniors and CDFs by meeting up weekly on Teams. The medical director, managers and medical staffing have been very grateful that the juniors have been able to adjust the rota to accommodate reduced on call staff. My management and leadership skills have really been put to the test! I saw how people respond to crisis situations differently and regular communication helps ensure better team working.

Kathryn: Talks about redeployment caused a lot of anxiety for people early on, but none of the psychiatry trainees in Wales were redeployed in the end. I'm chair of the HEIW Trainee Think Tank and so have been involved in thinking about trainee wellbeing at this time. We've been meeting over Skype which I think is something that we will carry on as it has made it easier for people to attend. We've also started having some of our SpR teaching and Balint groups over Zoom.

Fifi: I am looking forward to returning to in-person teaching as I miss the banter and spontaneous catch up with people. In Scotland, regional teaching has all been cancelled but our hospital restarted journal club and case conferences on Teams. This has worked really well so far with good attendance and positive feedback. I also feel really lucky to be able to attend free online Webinars throughout the country including ones organised by the College. I was able to hear reflections from specialist Paediatric Liaison CAMHS services in Oxford NHS Trust and kept updated with experts organised by PICU consultant at the Maudsley Hospital.

Kathryn: Yes, I think it will make it easier for us from the devolved nations to attend this kind of national events. Talking of national things, when I last saw you, you were about to submit your application to CAMHS higher training. How did you get on?

Fifi: I've managed to secure a CAMHS post in the West of Scotland! I'm so excited and nervous about moving to Glasgow.

Kathryn: Congratulations!

Fifi: Thank you. We didn't have interviews this time around. It was just the self-assessment form which may have disadvantaged some trainees. Training, ARCP and Exams have had to adapt in view of the pandemic too.

Kathryn: It will be interesting to see. Thank you for the call, it's been good to catch up and talk about these things, and to hear about your experiences in Scotland. I'm glad that you are keeping well, and congratulations again on your higher training post!

Fifi: Take care and keep in touch!

Kathryn: You too and speak soon.

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### ***Contacts and leads within the executive***

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

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