Faculty of Child & Adolescent Psychiatry Executive Committee Newsletter

MARCH 2024

Chair: Elaine Lockhart

Vice Chair: Alka Ahuja

Finance Officer: Guy Northover

Editor's Note

Hello and welcome to our first CAP Faculty Newsletter of 2024. It's lovely to see **Spring** in the air. However, my sister-in-law in Bristol just sent me a picture of a snowman her children built over the weekend, so perhaps winter hasn't fully left us yet! Although this newsletter covers the last winter season, we want to use the Spring spirit to bring a fresh enthusiasm for our Faculty which works so hard on our behalf.

My name is **Meinou Simmons,** a CAP psychiatrist based in Oxford, and I am the new newsletter editor. I was recently approached by Elaine, Faculty Chair, to step into this role, due to my experience of writing a parent handbook on mental health. My first thought was I couldn't possibly fit this in too! However, I saw there was a newsletter sitting waiting to go out, and I had some skills which could be put to use, so I agreed to help. I have been ably supported by **Dr Asilay Seker**, the Psychiatric Trainees' Committee representative and **Hayley Shaw**, our Faculty Manager.

It has been inspiring to read about the busy hive of activity within the CAP Faculty and share some of the fantastic work done by colleagues. As well as **updates from the Chair and from Scotland, Wales and Northern Ireland**, we **announce 2023 Faculty prize winners** and consider the important work of the **CAPSAC** by its new chair Anupam Bhardwaj. We include an **update from CAPPS**, and we also have a few articles of interest including an **update on Bodily Distress Syndrome**. We also have a **link to a poem on racism** from colleague Abdullah Kraam, and an **opinion piece on leadership** by Sebastian Kraemer.

As always, we couldn't include all submissions as the Newsletter would then be too long, but hopefully this letter gives a flavour of recent activities and creative work. **Please do continue to submit short articles and notices to us** and we hope to be able to capture the diverse spirit of our Faculty in forthcoming newsletters.

Contents

The Chair's Blog

Elaine Lockhart

I'm sure we are all happy to see the days getting longer and the **spring bulbs appear**. Winter is often difficult for our patients with the pressure in schools cranking up and for some, the festive period is especially challenging, and it can be an effort for us to get up on those dark mornings.

We continue to see evidence of **increased referrals to specialist CAMHS**, along with workforce and funding figures which can explain why colleagues are finding our work both rewarding and challenging.

There has been an **increase in funding for health services** over the past few years with a significant **growth in the CAMHS workforce**. The recent **workforce census** in England, NHS Benchmarking Children and Young People's Mental Health Workforce Census shows how our teams have changed radically over recent years.

There has been an expansion of colleagues with 1 year's postgraduate training who can deliver some psychological therapies and the **rollout of mental health support teams** in schools is welcome. This now means that **doctors make up 3% of the CAMHS workforce**, with our numbers being fairly static over the past 8 years, with **high vacancy rates around the UK**.

You can see that the vast majority of clinicians (over 80%) have not been in their services for 5 years and often **psychiatrists are the most stable team members** who **carry a large part of the workload and the team culture**. More children than ever before are being seen in our services and whatever we do is inextricably linked with what can be provided within primary care, schools, social services and third sector organisations.

We have been thinking about this at the College with **ongoing work regarding updating reports which relate to job planning, caseloads and delivering safe and effective services**. It seems clear that we need to change how we work to give us sufficient time to focus on those children and young people who most need our

extensive training and expertise, to support our colleagues within our teams and within the network of children's services and to provide supervision, support and training to both medical trainees and those who are taking on roles previously held by doctors e.g. non-medical prescribers, physician assistants etc. These responsibilities, along with the importance of our work as clinical leaders are highlighted in the **latest update to the GMC Good Medical Practice**; Good medical practice 2024 - GMC (gmc-uk.org).

In the meantime, we have been continuing to promote our specialty and **focus on retention and recruitment as a priority**. There have been some welcome **additional higher training and run through training numbers** across the UK, with **recruitment running at around 80%.** This does mean that there is a need for consultants and SAS doctors to **provide additional training opportunities** for higher trainees in CAP, as well as for core trainees, paediatric and primary care colleagues. For many of us, this is one of the most enjoyable aspects of our work, but it can be difficult to fit this into our working week.

We are working with colleagues across the College to support better services for young people who need to make the **transition to adult mental health services** and to advise on how good mental health services can be provided to **18 – 25-year-olds.** Although we aren't funded sufficiently to meet the needs of 0 – 18's, never mind up to 25, we can **bring our developmental perspective to this work**. In the meantime, colleagues are being asked to work across this age range, both from child and adult services and I would welcome your thoughts about the need to work within our current CCT and how much training is sufficient to support working beyond this.

With 1 in 6 children and young people having a probable mental health condition, there is clearly a need for many others to join in with this work, ideally by working to promote good mental health, prevent disorders and intervene as early as possible in the development of mental illness. **Our work with paediatric colleagues continues** and it has been a real pleasure developing the programme for our **Winter Institute on the 1st of March which is focusing on neurodevelopmental conditions** with the chairs of the British Association for Community Child Health and the British Academy for Childhood Disability. This is open to anyone working in CAMHS or Paediatrics and **has attracted hundreds of delegates**.

Leaders at the **Royal College of Paediatrics and Child Health** continue to **focus on mental health** and have **recently updated their position statement** on this topic; The role of paediatricians in children and young people's mental health - position statement 2024 | RCPCH

Many of you may have been watching the ITV programme about working in hospitals during the early days of the Covid-19 pandemic and although it is tempting to see this as an historical event, we know that our patients and services are still feeling its impact. **I've met with the panel for the next phase of the UK Covid-19 Enquiry** which **will focus on healthcare services**, and we are currently **preparing our submission**.

Hopefully as well as spelling out the many ways children, their families and our colleagues were affected by the pandemic and associated lockdowns, we can make **recommendations which will lead to further development of our services** which were already unable to meet demand before Covid-19 struck.

Colleagues on our executive committee and beyond continue to help us with many different areas of work in relation to children's mental health. Our work touches on so many other areas within the College and with national, regional and local partners which makes for fascinating and productive interactions with a whole range of people, and I am grateful on a daily basis to those who work so hard on our behalf. In the meantime, **I hope you enjoy the arrival of spring and hope to see as many of you as possible at our conference in September**, with information to come on our website page.

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Updates from Northern Ireland

Holly Greer

We are hopeful in **Northern Ireland that the restoration of the assembly** will start to **make changes to the health and social care system** here which is drastically under-resourced and under-staffed.

We have a **new Children's Commissioner**, Chris Quinn, who has an ambitious and inclusive **plan to support children and the services providing for them in NI**. Siona and I met with him along with Dr Richard Wilson and Emma Allen. It was a long and productive discussion where we highlighted the workforce and stigma issues

persisting within psychiatry, the pressures and lack of resources in CAMH services (and the lack of equity of service across the region), the number of children presenting to Emergency Departments in crisis (particularly those with ID) and the impact of the lack of school and social work placements is having on children's' mental health. We look forward to working closely with him over the next few years.

We are in the process of **planning this year's joint RCPSYCH NI CAP faulty/Ulster Paediatric Society conference.** This is always a really well attended and successful event, and we look forward to linking up with our paediatric colleagues.

Dr Siona Hurley (Vice Chair of CAP faculty NI) responded to the consultation on **the Independent Review of Children's Social Care Services in NI.** We also responded to the **hospital car parking charges consultation** and provided input into the review of the **ProtectLife2 Action plan.**

We are delighted to have funding for a **regional deaf CAMH service** based in the Northern trust, and also to have funding for the consistent **development of ID CAMHS** in each trust which will be slowly implemented over the next 5 years to provide equity of service for all children eventually.
The **regional Managed Care Network also continues to progress** with moving towards regional consistency in CAMH services, out of hours cover and inpatient provision as well as forensic and secure care mental health provision.

Updates from Wales

Amani Hassan

As I write this last newsletter in my capacity as chair of the faculty, I find myself feeling a mix of sadness but also gratitude. As you know, **I will have stepped down as chair** at the end of January 2024. The last couple of years have seen us collectively go through **immense change**. Whether it be navigating one of the largest public health crises in recent memory to managing a once in a generation shift in ways of working, there is no denying we have had to show **immense resilience and agility as a profession.** We can take pride in how we have adapted in face of all this uncertainty.

In terms of impact, the RCPsych Wales Child & Adolescent Faculty was delighted to host a **presentation by Dr Cass on the Independent Review of Gender Identity**

Services on the 27th of October 2023. Whilst unfortunately the event could not be recorded, the final review came out in early 2024.

In addition, the college hosted a **virtual National Mental Health Debate for Young People** on the 15th of December 2023. The debate was for pupils in year 6 and discussed the motion, *'Are young people involved in decision making*?'

Going forward, the College in Wales will be hosting a **schools' conference**, which will host our **long-standing Mental Health Debate programme for primary schools**. To complement this, planning for further topical workshops is also underway.

With regards to the new Faculty chair, an election process is underway. Finally, to say that it has been a pleasure to work with all of you. I look forward to an **exciting new phase for the Faculty under my successor** and may it be a tenure filled with success and impact.

Updates from Scotland

Kandarp Joshi

The CAP faculty in Scotland experienced a great buzz meeting **face to face to for the annual conference on 23rd November.** The programme had inspiring speakers from FY to a Prof in Child psychiatry as well as voices of young people. We felt the energy in connection perhaps feeling validated inside and on outside and wanting to do more for children and young people as well as our professional group.

We continue to on **campaign for 10% health budget for mental health and 1% budget for CAMHS** and have dashboards to help easily access this and workforce information for Scotland. We are engaging with a new minister and with change comes new opportunity. Sadly, the number of **capital projects in Scotland have been paused and funding gaps /saving targets are increasing**, which is likely to have a negative immediate effect on services which are already struggling to deliver waiting time targets. We continue to highlight the needs of our nation through the media.

The **multidisciplinary workforce has increased** for CAMHS **while the number of vacancies for consultant psychiatrist remains high**. The role of the psychiatrist is ever so challenging to keep running the service while also training and nurturing the new workforce.

Following the publication of **mental health and wellbeing strategy for Scotland in June** last year between Sept and Dec, the **following publications are relevant for all Child and Adolescent psychiatrists**, which not only inform the direction of travel but also **set out what 'good' looks like**:

Introduction - Children, young people and families outcomes framework - core wellbeing indicators: analysis - gov.scot (www.gov.scot)

Theory of Change - Early child development transformational change programme - gov.scot (www.gov.scot)

Core mental health standards - gov.scot (www.gov.scot)
Psychological therapies and interventions specification - gov.scot (www.gov.scot)

All three regions received investment to recruit to project management roles to progress **Regional CAMHS development** which includes **six pathways** in CAMHS OOH, CAMHS LD, CAMHS forensic, CAMHS Liaison, Intensive home treatment and IPCU for adolescents. We **eagerly wait for further investment** to progress on these pathways. We continue to input to the **Scots review of law** and the **development of National Care service.** Workforce report '**State of Nation'** has been **very useful to refocus on retention of staff and looking at training numbers**.

Winners of the 2023

Child & Adolescent Psychiatry Faculty Prize

The **recipient of the 2023 Gillian Page Prize is Dr Matteo Catanzano** for his paper: *Evaluation of a mental health drop-in centre offering brief transdiagnostic psychological assessment and treatment for children and adolescents with long-term physical conditions and their families: a single-arm, open, non-randomised trial*.

The recipient of the **2023 poster prize is Madeleine Mills, a medical student in Cardiff**, for her work entitled "*An audit on the efficacy of Maudsley family therapy for young people with anorexia nervosa (AN) and suspected autism spectrum condition (ASC) in Cardiff Child and Adolescent Mental Health Service (CAMHS).*

Updates from CAPSAC

Anupam Bhardwaj

This is **my first report as CAPSAC Chair after taking over from Suyog Dhakras**. I am starting to feel settled in the role and am grateful for all the support received from Suyog and Elaine during the handover process.

My priority was to **re-establish the SAC** as **most members of the previous SAC had completed their tenure.**

I am pleased that TPDs Meinou Simmons, Cara Maiden and Gordon Wilkinson have been appointed as members of the committee. We have representation from Wales (Cara) and Scotland (Gordon) and will be **looking to expand the SAC further** in the coming months. Asilay Seker will also be joining us as the trainee representative. I extend a warm welcome to all and am looking forward to working with them.

One of the priorities of the current SAC is to **review the implementation of the new curriculum nationally**. TPDs from all the schemes nationally have come together into a **UK CAP TPDs network** and **meet every 3-4 months** to share and identify solutions to various issues that may arise. The silver guide and the experience of TPD colleagues has been really helpful in this regard. This is turning out to be a really **valuable forum** and I am grateful to Meinou Simmons for setting it up and leading it.

Since taking over from Suyog I have been working with colleagues and trainee representative (Natalie Ashburner and Natasha Keyworth) on the **recruitment and retention strategy** developed by our faculty. We have held meetings with the Psychsoc committees from a number of medical schools and Foundation Year Trainees and Programme Leads to determine **how we can increase awareness and exposure to Child Psychiatry for medical students and FY trainees**. It is encouraging to see that there is a lot of interest in having more exposure to Child Psychiatry all round. Feedback from those who have been able to avail Child Psychiatry placements is extremely positive. Medical Students and FY trainees find

such placement rewarding and there is evidence that early exposure to specialities help trainees in choosing their speciality. The **limiting factor** seems to be the **availability** of Child Psychiatry **placements**. I would **encourage colleagues to link in with their local medical and FY schools to create more such placements and opportunities** and this can be a very rewarding experience. We are looking at other quick wins to improve awareness about our speciality and will keep you updated.

Legislation pertaining to CESR applications was recently amended. The new law now allows **GMC to expand the range of evidence that it can accept** from applicants via the CESR and CEGPR routes making the process more adaptable to an individual's knowledge, experience, and skills (KSE). This legislative change has introduced the '**New standard'** instead of CESR, which will not have the requirement of 'equivalence to CCT'. The New standard will be assessed on knowledge, skills and experience of the applicants to meet the competencies in each HLO of speciality curriculum, though doesn't require them to meet all the details in the curriculum. **The New Standards for Child and Adolescent Psychiatry CESR application have now been accepted by the GMC.** Demonstrating competency in Specialty HLOs remains the standard for assessing individual knowledge, skills, and experience. The new standards are available on the GMC website.

Marry Beth (Previous SAC Chair, ID) has been leading on the **proposal of a credential on Neurodevelopmental Disorders**. The work on the proposal is now complete and has been submitted to the College for approval. We have had discussions on whether the credential should be available to Child and Adolescent Psychiatry trainees and consultants as most of the competencies required for the credential should be covered in CAP training. Variability in training experience was cited as one of the reasons why this should be available to CAP trainees. SAS and Speciality doctors who want to demonstrate their expertise in Neurodevelopmental Disorders will also benefit. The proposal is due to be reviewed by the Education and Training Committee and I will keep you updated about its progress. The GMC has paused taking on applications for new credentialing before deciding on the process to proceed further. Those in the pipeline already can continue. **The college is continuing to adopt and evaluate credentials** for pilots.

I have also been involved with the **Assessment and Curricula Framework committee** in the review of the suitability of the **current formative assessment process for trainees**. There has been a review of Work Placed Based Assessments and the Portfolio. **Entrustability Based Assessments** have been considered to assess skills not covered by the current WPBAs. This has been an interesting piece of work, and I am hopeful will lead to constructive changes in the assessment framework for future trainees and will keep you informed about the progress.

And finally, we have released the topic for this **year's essay competition for medical students**. The topic is: ***Referral to CAMHS increase significantly at the start of school year. Are schools bad for young people's mental health?*** I am looking forward to the entries from medical students.

Poem *by Abdullah Kraam*

I hope the poem, along with the short introduction, is self-explanatory. My experience of racial abuse occurred approximately 13 months ago. Over time details have become less vivid like a photo or film changing from colour to black and white. However, the impact remains strong, especially when I have flashbacks. These flashbacks can be triggered by trivial things, such as grooming my beard.

In the poem I didn't provide a reason for why I let my beard grow into a jungle. The truth is, one day I realised that it had stopped growing due to the effects of the chemo. I was terrified. And every millimetre growth meant a small but important victory over this side effect. I never had the opportunity to explain this to my abusers because I was too unwell and had to focus on surviving. I know the length of my beard should not have mattered.

I had hoped that someone, whether senior, junior, auxiliary, patient or relative would intervene on my behalf directly or indirectly while I was too weak and frightened to defend myself. No one did. I want to commend the CEO of the Trust for their courage in agreeing to video me reading the poem and publish it on their website, as well as use it for training staff. It takes guts for a stand like that. And maybe, just maybe, someone who sees the video will be inspired to speak up when they witness racial abuse because they saw the video. We all live in hope.

Abdullah Kraam's Poem can be found at:

(https://www.youtube.com/watch?v=5UtgYOEh0PM).

Updates from CAPSS Executive Committee

Study application updates:
The CAPSS Executive Committee are now reviewing applications from 2 studies: a phase 2 application on neuroleptic malignant syndrome (NMS), and a phase 1 application on paediatric acute-onset neuropsychiatric syndrome (PANS).

ARFID Surveillance Study Update:
The first paper on the ARFID study is now available to download here.

Far Away from Home Study Update:
The Far Away from Home surveillance paper was published December 15th 2023 and is available to read here.

Committee News:
The CAPSS Executive Committee will be meeting this year on March 22nd. The Committee would welcome applications for the now vacant position of trainee member for Wales and the Republic of Ireland. If you would like to be considered for these posts, please contact CAPSS@rcpsych.ac.uk.

Masterclasses and webinars:
CAPSS are continuing with their programme of in-person masterclasses and webinars. Further information on all these sessions with links for booking are provided on the CAPSS events page. Professor Raja Mukherjee will be hosting a **masterclass on Fetal Alcohol Spectrum Disorders (FASD) on March 25th** at the College. Further information and booking can be found here. Recordings of past webinars are available to purchase from the website. On receipt of payment for your chosen webinar, the CAPSS team will provide a link to an online recording of the session.

CAPSS reporting and membership:
All consultant child and adolescent psychiatrists are automatically provided with the opportunity to participate in CAPSS studies. Please contact the team if you would like to advise of your preferred email address or a change of details for future communications. You can register or update your details here and see our website for more information on CAPSS studies. CAPSS studies are not currently in a period of active surveillance.

Bodily Distress Symptoms in Children & Young People

Tom Scurr, Rory Conn, Ginny Davies, Max Davie, & Lucy Blake

A guide to assessing and managing patients under the age of 18 who are referred to secondary care:

As a as a group of psychiatrists and paediatricians interested in Body-Mind connections, we have recently revised our national guidance on managing **bodily distress symptoms** in children and young people. These have been endorsed by the Paediatric Mental Health Association and have been published on both their website and the soon-to-be revamped RCPsych Child and Adolescent Psychiatry webpage. They are also being reviewed by the RC Paediatrics and Child Health board for endorsement.

What are the guidelines?

Overview of the Guidelines

This guide, designed primarily for secondary care doctors and the wider MDT, provides advice and helpful tools for the assessment and management of children and young people (CYP) with bodily distress symptoms. The aim of the guide is to ensure healthy relationships between the care provider (staff, as well as institution) and care receiver (CYP and carer/s) and to minimise the risks of recurrent presentation, including missed educational time and inadvertent medical child abuse. This is a complex and difficult area, where clinicians need to hold uncertainty and anxiety both from parents, families, and themselves.

Changes in Version 2 :

1. We have brought our guidelines in line with current research and thinking by changing from using medically unexplained symptoms to **bodily distress symptoms** and bodily distress disorder.
2. We have **defined these terms** for clarity in our introduction and briefly explained and evidenced this change.
3. We have streamlined and **reduced** our discussion around changing terminology in this area.
4. Given the recent Perplexing Presentation and Fabricated or Induced Illness guide released by RCPCH, we have significantly reduced this section, **removed this overlap** from our guide, and have **linked** to the PP/FII document directly.

5. We received significant criticism from some organisations online for the language used in our FII section previously, **this has been removed**, and the language used in our guide has been updated to address this.
6. We have **updated the referenced evidence base** for our guide in line with current research and understanding.
7. This guide has **been reviewed by the executive board of the PMHA** and we have made alterations to bring our document in line with their feedback.

Background - Bodily Distress Symptoms and Disorder

The term bodily distress describes a broad range of clinical presentations, rather than a diagnostic condition in its own right. The symptoms an individual experiences (from bodily pains through to loss of neurological function) are not explained by physical examinations or investigations alone. However, symptom experience is no different from that arising in the context of known pathology; symptoms are just as real and are certainly no less anxiety-provoking.

Bodily distress symptoms (BDS) and bodily distress syndrome have become widespread terms since first defined in 2007, as practice has moved away from medically unexplained symptoms (MUS), and BDS has become an umbrella term for the many overlapping functional syndromes and somatoform disorder[1-3]. The ICD-11 has now defined Bodily Distress Disorder as the presence of distressing symptoms that cause excessive attention or preoccupation to be given to them and may result in multiple contacts with healthcare providers[4]. These bodily distress symptoms meet ICD11 criteria for the disorder when they are present on 'most days for at least several months', and is not alleviated by 'appropriate clinical examination, investigation, and reassurance'. However, this guide will use bodily distress symptoms as the acronym BDS to disambiguate from the BDD acronym as Body Dysmorphic Disorder.

<u>Why do we need these guidelines?</u>

Impact of Bodily Distress on Children and Young People

Experience of bodily distress symptoms are common and affects around one in four children to some extent. This can range from mild, transient physical symptoms to a severe, debilitating, and enduring disorder. These symptoms can be persistent and distressing in up to 10% of children and adolescents, and the same proportion have a significant functional impairment[5]. The symptoms should be taken seriously, and a range of services need to be available to Children and Young People (CYP) with these problems.

We also know that bodily distress symptoms can occur alongside a physical disorder e.g. non-epileptic seizures in someone with epilepsy, or abdominal pain in excess of pathology, in someone with inflammatory bowel disease[6]. We have written this guide for medical professionals to help them manage the uncertainties of this complex area, and with holding this uncertainty for themselves where diagnoses feel unclear or even unhelpful.

Impact on the NHS

For some CYP, bodily distress will resolve spontaneously. However, some will develop chronic symptoms and the mainstay of their treatment will be symptom control. From research in adult populations, it is known that bodily distress presentations cost the NHS significant amounts of money (£3.1 billion per annum in 2020)[7].

Primary care clinicians play a vital role in managing bodily distress and this work needs support and acknowledgement by those working in secondary care. Approximately 30% of adults with BDS seek direct healthcare support, of which only 1% present to secondary care[8]. This adult group present frequently, to multiple specialities and often undergo extensive and unnecessary physical investigations, and even treatment – something we've long understood as leading to a significant risk of iatrogenic harm[9]. Similarly, 30% of children with BDS will present to primary care[5], and are therefore likely to also be at risk of this iatrogenic harm.

Where are the guidelines?

We hope that with clearer guidelines that include up-to-date terminology and a range of information covering when to think about bodily distress symptoms, how-to guides on starting these discussions with children/young people and their families, managing over- (and under-) investigation, and when to refer for further investigations, we can help support our colleagues in effectively managing these presentations. Our guidelines are available here.

They will also be published on the soon-to-be newly revamped RCPsych CAP webpage – watch this space!

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Leadership and imagination in psychiatric practice

Sebastian Kraemer

It is Wednesday. You are chairing a case conference about a 16-year-old boy - B - who has recently been discharged from a six week stay in an in-patient psychiatric unit, for depression. He was admitted two days later to a paediatric ward after taking 80 Paracetamol tablets. There he was treated for poisoning and seen by a paediatric liaison psychiatrist. After four days in hospital his liver function tests were normal, and he was deemed ready for discharge and CAMHS follow up. He is well known to social services, but his allocated social worker left several months ago and has not been replaced. Before his in-patient admission he had attended an offsite educational unit, but they have refused to take him back because of the risk.

You are a newly appointed consultant in the local community CAMHS. Besides yourself there are six people in attendance, including a senior GP who is also the family doctor of B's most recent foster parents, who are not sure whether they can take him back. They are not in the meeting. There is a duty social worker who does not know B. Others present are a core psychiatric trainee from the paediatric ward, a consultant psychiatrist and senior nurse from the adolescent unit, and an experienced specialist teacher from the pupil referral unit.

"A principal role for child and adolescent psychiatrists is providing clinical leadership within multi-disciplinary teams, to engage with other key workers in complex cases and to facilitate respect for different points of view. Though it takes more time

and effort, inter-agency collaboration is likely to improve clinical outcomes. This is ethical practice" [says a recent draft policy document from RCPsych CAP faculty].

You have a brief referral from the paediatric department, which gives details of B's admission, investigations and treatment and a summary of the liaison psychiatrist's view that he is not now suicidal but needs ongoing treatment. B is not on any medication. A trial of SSRIs in the adolescent unit had no useful effect.

There is evident pressure from all sides that the young person is allocated to you or one of your consultant colleagues immediately, but you have a long waiting list. You feel obliged to offer a psychiatric assessment before the weekend, but now also see that there is a great deal of useful information in the room, an opportunity not to be wasted. Already you have less than an hour, and the GP says that she has to leave in 10 minutes. She is positive about the foster parents who feel very betrayed by B, having devoted 18 months to his care, which had been going well until he got in with a gang in the neighbourhood.

You ask the GP first, then; 'tell us something about B and his latest foster parents.' She tells you that before his psychiatric admission B had heard that his father - whom he barely knew - had recently been released from prison after a sentence of several years for GBH. The boy became very disturbed, talking a lot about his parents yet resisting the foster parents' inquiries into his history. The nurse and psychiatrist from the adolescent unit are evidently quite attached to the boy; you sense that they had temporarily replaced the foster parents. But like them, they had not been able to learn much more about his family except that his father left when he was 9 months old, leaving mother with B and a sister aged two. Despite several requests they had been unable to get background information from social services. They reported that his mental state had improved considerably during his stay where he made good use of the community, but not of the individual consultations he was offered. B has no contact with any of his family, except from his paternal grandmother who sends him a birthday card every year. The social worker does not have the file – she was not told about this meeting until half an hour before – so has nothing to add. While thanking her for attending, you try to conceal your irritation with social services. The specialist teacher says that B is quite articulate and clever, but is behind in maths and English, neither of which interest him. On his headphones he listens to a lot of heavy metal music (it crosses your mind that this might have been his father's favourite listening). The teacher likes him but is like a brick wall when there is any suggestion of his returning to the unit. They do not want a potentially suicidal boy placed there. The core trainee psychiatrist from the paediatric ward says that B seemed content there, getting on well with the ward teachers and with a couple of other teenage boys, one of them with asthma and the other being investigated for chronic fatigue.

This [fictional] scenario is not unusual. The question is, what do you do? Our default impulse is to get a diagnosis and some idea of risk, but you begin to realise that a significant part of the assessment is already happening in the room, and in your head. What do you think? Do you have a formulation in mind? Does any kind of plan follow from that?

(*More information about Sebastian Kraemer can be found here.*)

RCPsych Emergency Plan

RCPsych International Advisory Committee

The Royal College of Psychiatrists (RCPsych) is a global membership and advocacy body committed to promoting excellent mental health services, supporting the prevention of mental illness, training outstanding psychiatrists, and advocating for quality and research in the field of psychiatry. While aiming to be a strong and progressive College that supports its members in delivering high-quality patient-centred care worldwide, the RCPsych has accumulated a wealth of knowledge through its responses to various international emergencies, including those arising from natural and eco disasters, political upheaval, and acts of violence. In these responses, the College prioritises respect for the affected regions' people and cultures, refrains from taking political positions or endorsing specific factions, and remains focused on its core mission of enhancing patient care. The RCPsych will engage in relief efforts only when it can make a substantial and meaningful contribution.

The below summarises support offered to colleagues and their patients impacted by crises:

- Developed an Emergency Response Plan that functions as a set of guidelines for the College to offer assistance to partners within affected communities.
- RCPsych Officers committed to regular, three-weekly Crisis Response meetings to monitor developments and support offered.
- A comprehensive list of freely accessible resources on the RCPsych website, including an eLearning module on Complex humanitarian emergencies and guidelines on mental health and psychosocial support in emergency settings.

- Newly commissioned translations of the Coping after a traumatic event patient leaflet in Ukrainian, Russian, Turkish, French and Hebrew. To complement existing translations in Arabic, Kurdish, Urdu, Farsi and Sindhu.
- Reached out to the presidents of sister psychiatric associations to offer our support and resources, including those in Ukraine, Poland, Hungary, Slovak Republic, Moldova, Romania, Myanmar, Sudan, Libya, Morrocco, Turkey, Syria, Palestine, Israel, Pakistan, Sri Lanka and India.
- Reached out to diaspora groups as well as individual members in the UK and internationally, who may have been affected by an emergency to offer support as well as to raise awareness of the College's Psychiatrists' Support Service.
- Organised and recorded a webinar on Psychological First Aid and its application in crisis settings.
- Organised and recorded a webinar on mhGAP Humanitarian Intervention Guide, which is a mental health toolkit designed for emergency settings.
- Contacted NHS England over medication shortages in Sri Lanka, West Bank and Ukraine

Call for LBGTQ+ Lead for RCPsych CAP Faculty Executive Committee

The Child and Adolescent faculty executive committee is **seeking a colleague who will be our lead for LGBTQ+.** Although we have an Equalities Lead, we recognise the importance of providing leadership in this area for our patients and colleagues.

Contacts and leads within RCPsych CAP Faculty

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

Contact the Faculty and any of the contributors c/o
Hayley Shaw, Faculty & Committee Manager: Hayley.Shaw@rcpsych.ac.uk

Elected Members

Dr Elaine Lockhart - Chair

Prof Alka Ahuja - Vice Chair

Dr Guy Northover - Finance Officer

Dr Omolade Abuah

Dr Ashley Liew

Dr Sami Timimi

Dr Eilis Kennedy

Dr Pallab Majumder

Dr Mudasir Nazir

Dr Jenny Parker

Dr Liz Searle

Dr Dan Hayes

Dr Kathryn Hollins

Patient and Carer Representatives

Anna Kirkwood - Patient Representative

Rhiannon Hawkins - Patient Representative

Toni Wakefield - Carer Representative

Sam Young - Participation lead

Co-opted members

Dr Anupam Bhardwaj - Specialist Advisory Committee (SAC) Chair

Dr Sarah Jonas- Lead for Safeguarding

Dr Ananta Dave - RCPsych Presidential Lead for Wellbeing and Retention

Dr David Kingsley - Lead for Personality Disorders/QNIC

Dr Nick Barnes - Sustainability Champion

Dr Catriona Mellor - Sustainability Champion

Dr Jose Mediavilla - QNCC Link

Dr Daniel Hayes - Lead for Mental Health Act/Inpatient Care

Dr Susan Howson - CYP Mental Health Coalition / End Child Poverty Coalition link

Dr Suyog Dhakras - RCPsych Lead for Training and RCPCH link

Dr Rory Conn - Lead for website

Dr Richard Graham - Lead for Online Harms

Dr Suparna Sukumaran - Equality Champion

Dr Jeyabala Balakrishna-General Adult Faculty link

Dr Prathiba Chitsabesan - National Clinical Director for CYPMH- NHSE

Dr Laura Sutherland - CAFPEB Editor

Sonia Hurley - Vice Chair of CAP Faculty in Northern Ireland

Amani Hassan - Chair of CAP Faculty in Wales

Dr Holly Greer - Chair CAP Faculty Northern Ireland

Thomas Hillen - Medical Psychotherapy Faculty link

Kandarp Joshi - Chair CAP Faculty Scotland

Ruth Garcia Rodriguez - Chair Paediatric Liaison Network (PLN)

Dr Victoria Chapman - Eating Disorders Faculty link

Dr Isabel Paz - Chair Paediatric Liaison Network (PLN)

Dr Amy Blake - Intellectual Disability Faculty link

Dr Argyris Stringaris - Psychopharmacology Committee link

Prof Paul Ramchandani - Lead for Early Years, Perinatal Faculty link

Dr Kapil Sayal - Academic Faculty link

Dr Karen Street - RCPCH link

Dr Seena Praveen - Lead for Gender Identity

Dr Meinou Simmons - Newsletter Editor

Trainee Representatives

Dr Asilay Seker - Psychiatric Trainee Committee (PTC) representative

Dr Omar Medany

Dr Natasha Keyworth - Run Through Training Programme representative

Dr Natalie Ashburner

Regional Representatives

Dr Nicky Adrian - London South West

Dr Nisha Balan - Trent

Dr Siona Hurley - Northern Ireland

Dr Shermin Imran - North West, Chair of RR forum

Dr Triveni Josh - West Midlands

Dr Monica Nangia - North West

Dr Sara Ramirez-Overend – Eastern

Dr Cassandra McClintock – Yorkshire

Dr Jujinder Singh - West Midlands

Dr Tessa - Myatt Mersey

Dr Monica Nangia - North West

Dr Femi Akerele - South West, Chair of RR forum

Dr Edward Pepper - Yorkshire