



# The Newsletter



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## In this issue...

I have combined the Autumn 2011 and Winter 2011/2012 Newsletters to produce this bumper issue! In it we have updates from the Executive in The Chair's report from Margaret Murph, on Scotland from Kathy Leighton and we have feedback from the new trainee representative, Louise Morganstein. We have information about IAPT and the Early Intervention network and the prize winning medical student essay from Chantelle Wiseman.

We have information about ChiMat, two new Ofsted reports, and courses on Psychodynamic Psychotherapy and Epilepsy which may be of interest to you. I am hoping that with the help of the Faculty all recent editions of the newsletter will appear on the website shortly!

**Kay Harvey, The Editor**

## The Chair's Column

### Margaret Murphy

Dear Colleagues,

I am sure that wherever you work many of you are experiencing change or uncertainty at work. One of the challenges for us is trying to ensure that children and young people's mental health isn't over-looked and that our members are supported in providing a good service.

We thought you might want to know about some of the work the Executive is doing on behalf of the Faculty and more importantly we would like feedback from members.

Firstly, we want to think about how we engage with and involve our members. As a Faculty we are fortunate in that we have no shortage of members coming forward to stand for election to the Executive and willing volunteers for CAPFECC and other roles. However, we know there is always room for improvement. For this reason Gillian Rose, [gillian.rose@nhs.net](mailto:gillian.rose@nhs.net) our new Vice-Chair will over the next few months be asking you how we can improve member involvement. Liz Fellow-Smith and Helen Rayner who have also recently joined the Executive are revitalizing the website and will also want to know what you like/ don't like about it and what additional information you would find useful.

The English Minister for Health has just announced the funding for the Children and Young People's IAPT. Raphael Kelvin has outlined some of the details in his article and more information is available via the IAPT website. A key difference to the original IAPT project for adults is that it isn't the development of a new service separate from secondary care services but is aimed at improving outcomes in existing CAMHS services by addressing skills gaps and changing the way outcomes are measured and used. Faculty members have been involved in each of the workstreams (outcomes and evaluation, service design and curriculum) and the College is co-hosting the 'Critical Friends Group' along with the BPS and New Savoy Partnership. Again for this topic please email your views and experience to Thomas Kennedy at the College [tkennedy@rcpsych.ac.uk](mailto:tkennedy@rcpsych.ac.uk) or to myself.

On a less positive note the College Council is aware that many of our members are involved in re-negotiating job plans as the NHS across the UK is going through changes and Trusts re-organize. In recognition of this all Faculties, including ours, have been asked to put together guidance on the role of the consultant and what constitutes a 'do-able' job. The intention is that this document should be used alongside the BMA guidance on consultant job-planning. Liz Fellow-Smith is leading this work [elizabeth.fellowsmith@wlmht.nhs.uk](mailto:elizabeth.fellowsmith@wlmht.nhs.uk) and would welcome ideas and feedback on particular problems and challenges members are facing.

Many of you will be aware of the Joint Commissioning Panel (JCP) for Mental Health (see link) which is producing guidance for commissioners on how to commission good mental health services. As the JCP is a joint venture with a range of partners including the Royal College of General Practitioners (RCGP) the guidance will be widely distributed including to every member of the RCGP. In relation to our speciality we have started work on

guidance for commissioning services for young people in transition from CAMHS to AMHS as well work on commissioning CAMHS services both of which should be completed by spring 2012.

The Department of Health in England is about to start work on CAMHS Payment by Results. The Faculty has agreed to send representatives to join the Dept of Health development group. We hope we will be able to add the experience/ perspective of our members as well as keeping our members informed of progress.

The Faculty Child and Family Public Education Editorial Board (CAFPEEB) led by Ann LeCouteur continues to develop and produce resources to increase public awareness about children and young peoples mental health. One of these activities is the series of leaflets for young people, their parents/carers, teachers and other professionals supporting them. These leaflets are regularly reviewed and updated. The Board works closely with the college Public Education Editorial Board and several other organizations. We are looking for members who would be interested to join CAFPEEB and become involved in this work - anyone who is interested should contact Greg Smith [gsmith@rcpsych.ac.uk](mailto:gsmith@rcpsych.ac.uk) or Deborah Hart [dhart@rcpsych.ac.uk](mailto:dhart@rcpsych.ac.uk) initially.

Many of you will have seen the reports in the medical press about the on-going problems in recruitment to core training in psychiatry. Feedback from those involved in recruitment is that the core trainees selected have been high quality but there are problems in relation to the numbers of trainees coming forward. The College has appointed a lead for recruitment and each division will appoint a lead - the aim being to tackle this at a national as well as at a regional level. A range of strategies are being considered. Our Faculty members can have particular input in helping develop events that reach secondary school pupils; involving medical students by developing special study modules or summer schools - these can either be during the 'psychiatry teaching block' or 'paediatric teaching block'. We would be interested in hearing from you about any innovative ideas/ experiences.

Finally, it was good to see so many of you at our conference in September. For me, the outstanding features were the enthusiasm and interest of our members and the really excellent talks. The programme committee are keen to ensure we continue to provide high quality conferences which are value for money - feedback and suggestions for topics you would like covered are very welcome.

Best wishes

**Margaret Murphy**  
**Chair of Child and Adolescent Faculty**  
**[margaret.murphy@cpft.nhs.uk](mailto:margaret.murphy@cpft.nhs.uk)**

## Report from Scotland

### Kathy Leighton, Chair of Scottish Division

The Child and Adolescent Psychiatry Faculty has a membership of over 230 Child and Adolescent Psychiatrists throughout Scotland. The Faculty Executive meets four or five times a year and minutes are available on the Royal College of Psychiatrists in Scotland web page. We last met on 10 November 2011 and our next meeting is planned for 2 February 2012. We also hold an Annual General Meeting associated with an Academic Day in November and the 2011 event was held at the Thistle Hotel in Glasgow on Friday 25 November 2011. This year we held our Academic Meeting in association with the Learning Disability Faculty of the Royal College of Psychiatrists in Scotland. A number of speakers were invited and presentation topics include Advances in Genetic Testing and Developmental Disabilities, Inborn Errors of Metabolism presenting to Psychiatry and Adolescents, Pervasive Developmental Disorders and Co-morbidities and a session on working together in epilepsy.

Recent themes for discussion at our Faculty Executive include Generic Integrated Care Pathways for CAMHS, CAMHS Competency Framework and CAMHS Balance Scorecard. Faculty members have participated in Scottish Government and Healthcare Improvement Scotland and NHS Education for Scotland Groups who have been leading on these pieces of work which have now passed the consultation phase and are available online. A national event took place on the 16 November 2011 at Murrayfield where information about these work streams were shared with the CAMHS community.

Our Faculty has representation on the Royal College of Paediatrics in Child Health Committee in Scotland and the RCPCH Child Protection Committee. Faculty members have contributed to a report lead by RCPCH on Community Child Health in the 21<sup>st</sup> Century which is nearing completion. The RCPCH Child Protection Annual Conference was held 27 October 2011 at Stirling Management Centre. The topic was Core Issues from Paediatric Evidence.

The CAP Faculty regularly contributes to consultations and has recently contributed into consultations on the GMC Child Protection Guidance for Doctors, Substance Misuse Detainees, Adult Protection and Review of Post Graduate Education and Mental Health Strategy Consultation in Scotland.

If any member wishes further information please see information on Royal College of Psychiatrists website or contact me [Kathy.Leighton@ggc.scot.nhs.uk](mailto:Kathy.Leighton@ggc.scot.nhs.uk) or Anne McFadyen, Faculty Secretary ([Anne.McFadyen@nhs.net](mailto:Anne.McFadyen@nhs.net)).

**Dr Katherine M Leighton**  
**Chair of Scottish Division**  
[Kathy.Leighton@ggc.scot.nhs.uk](mailto:Kathy.Leighton@ggc.scot.nhs.uk)

## **Child and Adolescent Psychiatry – a view from training**

### **Louise Morganstein and Fareeha Amber Sadiq**

Firstly, we would like to introduce ourselves as the new National CAP Trainees reps. We took over from Myooran Canagaratnam in September 2011. We are both trainees on the Tavistock Rotation which is based in North London. Amber studied for undergraduate and postgraduate exams in Glasgow, moving to London for higher specialist training in 2007. Louise studied as an undergraduate in Birmingham and then worked in London for her House jobs and Higher Specialist Training. Our backgrounds and interests are different however we do share the common aspirations of making positive contributions to the mental health of young vulnerable people and their families. Through our roles as reps, we are looking forward to meeting and communicating with the wider group of trainees.

There are many issues currently at the forefront of CAP training including the curriculum revision and the future post-CCT. Therefore, it is really helpful and important that there is a trainee forum for discussion of these issues. Also, if any trainees have questions or concerns that they wish for us to share at the College meetings, then please let us know. We will be attending the CAP Faculty and CAPFECC meetings and will be organising the National Trainees Conference next year.

Following the various meetings, we will be sending out feedback to the trainees through the trainee Google group to keep them informed. We would like to thank everyone who contributed to the Google group communications last year and are actively encouraging others to sign up. Please help to spread the word regarding this group amongst trainees in your region.

To join, trainees just need to send an e-mail to [cap.sprs@gmail.com](mailto:cap.sprs@gmail.com) and they will be added to the google group.

### **Life as CAP trainees**

When we were discussing writing this piece for the newsletter, the dominant theme that emerged was the experience of being Higher Specialist Trainees in Child and Adolescent Psychiatry. This links with the wider issue of recruitment and retention in Psychiatry and how we share our own experiences about our work with medical students, other trainees and with our colleagues. We were both drawn to the profession by the privilege and opportunity to contribute to vulnerable young people's developmental trajectories, working closely with families and professional systems. Multi-disciplinary work is a particular strength of our profession and allows for thoughtful discussions and management regarding the young people and families we see.

The interest in child development was stimulated for us in our adult jobs and we were also fortunate in having the opportunity to work in CAMHS jobs as core trainees. We are also aware that newer doctors in their foundation years also can have an opportunity to work for 4 months within CAMHS too. The projects currently going into schools with SSE medical students and summer schools in Psychiatry are also positive strategies as these are all targeting critical periods for encouraging and inspiring future generations to join us in our developing field.

Further linked with recruitment and increasing awareness of our diverse and varied profession, together with Andrew Hill-Smith, we have been editing the Child and Adolescent Psychiatry entry on the NHS careers website. For a medical student or junior doctor faced with thinking about their future higher specialty training, we think that this is a very helpful resource to help inform them in their decision making. In updating the entry, what is most striking is the breadth of interesting areas one can become involved in, reflecting the wide age range of children and young people we see. This ranges from infant mental health to adolescent substance misuse. How do you even start to begin to describe an 'average' day in the life of a Child and Adolescent Psychiatry trainee? When asked to list the "procedures" that you might perform as a CAP, how can one give a succinct explanation of the intricacies and sophisticated communication skills needed to communicate effectively with a distressed adolescent when asked by the young person, "Am I going to get better?" in an inpatient job, or chair and facilitate helpful discussions in a CPA meeting?

### **Being an agent for change**

Fast forwarding into the future, the inevitable prospect of leaving training and finding a Consultant job in a climate of cuts feels even more daunting than ever. As many CAMHS teams are currently facing restructuring, the position of the trainee remains relatively stable and it is often difficult to fully comprehend the changes that teams are encountering as we are not subject to the same pressures. Equally, at a time when services are being asked to improve efficiency and quality, both of which require a good working knowledge of how services operate and a longer term view, it might be helpful to ask ourselves how should trainees get involved in some of this thinking and work.

As trainees, we are used to adapting and gaining considerable exposure to a number of different clinical contexts within our Higher Specialist Training. We are developing and contributing to each others learning and can develop good solid skills to help spread ideas about change and share experiences of working in different types of services. Sir Bruce Keogh, refers to junior doctors as 'Agents for Change' – therefore we are keen to discover and discuss what we need to do to take up this challenge!

***Louise Morganstein and Fareeha Amber Sadiq***

**National CAP trainee reps**

[cap.sprs@gmail.com](mailto:cap.sprs@gmail.com)

## **A Message about the CYP IAPT Development**

**Raphael Kelvin, National Professional Advisor for CYP Mental Health,  
Department of Health, England**

Children and Young People's: Improving Access to Psychological Therapies (CYP IAPT) forms a central focus for current policy implementation. It is a direct follow-on from the mental health strategy and brings together a number of key longstanding objectives including:

- Boosting delivery of NICE approved and best evidence based care

- Optimising use of existing resource
- Demonstrating effectively the effectiveness and efficiency of what we do
- Enabling the development of multidimensional clinically useful outcome indicators: from clinician, patient and carer perspectives; that will inform day to day practice
- Building into care and services real and meaningful patient participation to ensure we deliver the care that people want and that we can demonstrate this

This is a service wide change and quality improvement programme involving all staff at all levels of services, patient participation, consultants, therapists, managers and service leaders. It is a programme that has wide-ranging buy-in from across the sector and from user and carer groups.

There is understandable anxiety about the difficult financial situation - I have and am seeing this daily - but the transparency and focus that CYP IAPT offers to make our services and what we do much more understandable and accessible to decision makers. This will bring benefits both to CYP IAPT sites and over time to CAMHS as a whole. I believe this will work in the favour of services for CYP with mental health problems going forward. Commissioning decisions will be made on the basis of improving mental health outcomes, and this project should help us to demonstrate what we achieve every day, the complexity of our work across community CAMHS in all treatment areas, not just in the CBT for anxiety and depression and parenting training for conduct disorder in 3-10 year olds that is featured in the therapist training in year one. Indeed the early roll out of the programme is being very well received. I very much hope we will be able to build on this momentum going forward; quietly I am saying to you watch this space...and also consider how you may contribute and join the development.

We intend to link the CYP IAPT development with the evolution and development of the CAMHS Payment by Results (PBR) process so that PBR development is predicated on high quality care and practice. In this way, in time, we shall be able to understand both the quality and cost elements together to establish 'value' in practice. It is more important than ever to demonstrate the full cost and full quality of what can be achieved in CYP MH care, including the cost of no care. Together the CYP IAPT and CYP MH PBR will lead services to fit much better with longstanding and likely future NHS and Social Care policy directions of travel in particular the definition of Quality care as demonstrated by transparent outcomes informed care processes. The building of nationwide learning and development networks that can form the basis for all kinds of networked audit, improvement and research and development across all domains of service delivery, processes of care, content of care and data arising and its interpretation is a further benefit.

This is a real opportunity to push our services forward, to grasp opportunities in ways we have at times struggled to do in the past, and so despite these difficult times we find ourselves in, be prepared well for the future and hopefully for better economic times to come.

For more information see the IAPT website

<http://www.iapt.nhs.uk/children-and-young-peoples-iapt/>

or contact one of the DH CYP IAPT implementation team

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Kathryn Pugh, Manager for CYP IAPT

Professor Peter Fonagy, Clinical Lead

Dr Miranda Wolpert, Informatics Lead

Ann York, Service Redesign Lead

Karen Turner, Senior Responsible Officer, Dept of Health

Dr Sheila Shribman, National Clinical Director for Children, Families and Maternity and Chair of the CYP IAPT steering board

## **Early Intervention Network becomes an Inter-Faculty Venture**

The Early Intervention (EI) Network was initiated by the General & Community Faculty in 2009. Springing from a strong evidence base and the NHS Plan in 2000 and the subsequent Policy Implementation Guide, EI services are established in most areas of England for young people with a first episode of psychotic illness; prompt, proper care can radically improve their chances of recovery and a return to a normal developmental plane into adulthood.

Given the rapid increase in incidence of first episodes of psychosis from the early teens into the late twenties EI services were conceived as targeting the 14-35 year period. Even the most successful EI teams usually remain marooned within adult services, despite having many characteristics of CAMHS such as promoting the importance of family systems, developmental approaches and a tolerance of diagnostic uncertainty. Few teams have effective links between adolescent and adult services, such that the transition between services can be a disastrous disjunction for young people, turning on a birthday. While most mental health disorders affecting the majority of life begin in adolescence, few services are configured to address this.

A joint EI Network can help to achieve better integration and discuss some of the major questions for EI such as how the approach can be:

- developed into an innovative, youth-based psychiatry reflecting the underlying biological, psychological and social development of the second and third decades;
- broadened to affective illness, emerging personality disorder, OCD and beyond;
- protected in financially challenging times despite evidence of cost effectiveness;
- used to develop evidence-based interventions defining primary and secondary prevention in psychiatry.

The EI Network has debated all these topics, been a forum for sharing ideas and a means of support for psychiatrists. Current members and the General & Community Faculty

welcome the opportunity to become a joint faculty forum. Once we have a joint membership the EI Network can decide its new priorities.

See:

<http://www.rcpsych.ac.uk/specialties/faculties/generalandcommunity/aboutthefaculty/networks/earlyinterventionnetwork.aspx> for further information

[http://www.nhsconfed.org/Publications/Documents/early\\_interventionbriefing180511.pdf](http://www.nhsconfed.org/Publications/Documents/early_interventionbriefing180511.pdf) for the latest clinical- and cost-effectiveness briefing

Email: [gandcfaculty@rcpsych.ac.uk](mailto:gandcfaculty@rcpsych.ac.uk) to join the network

## **What are the Potential Benefits and Detrimental Effects of Giving a Child with a Behavioural Problem a Child Psychiatric Diagnosis?**

**Chantelle Wiseman, Medical Student Essay Prize Winner**

### **Introduction**

Disruptive behavioural disorders, which consist of Conduct Disorder (CD), Oppositional Defiance Disorder (ODD), and Attention Deficit Hyperactivity Disorder (ADHD), are the most prevalent psychiatric diagnoses for poor childhood behaviour in the UK<sup>1,2</sup>. ADHD can also be considered to be a neurodevelopmental disorder. Diagnosis with one of these conditions can elicit effective treatment and support for the child and their family, which may have positive consequences for the wider society. However, there is concern that behavioural difficulties are not so much medical problems, but rather social disorders that society is trying to control through the medical profession<sup>3-5</sup>. A diagnosis may also bring feelings of parental failure, social stigma and criticism that the family are trying to use the diagnosis as an excuse for poor parenting.

In this essay I explore the effects of a diagnosis of a psychiatric condition for a behavioural disorder: firstly I give an overview of common behavioural conditions, using a case study to demonstrate their presentation, epidemiology, pathophysiology and management. I then describe the benefits and detriments to children, their families and the wider society when children are diagnosed with a psychiatric condition for a behavioural problem. Finally, I address what can be done to help overcome the difficulties these young people must face.

### **Behavioural Disorders**

#### **Differentials**

B is a 14 year old boy who was referred to Child and Adolescent Mental Health Services (CAMHS) when he was 12 because of impulse control difficulties around the consumption of unhealthy food, violence and disruptive classroom behaviour. He had diabetes, and his poor management of his condition and regular consumption of sweets had lead to very high blood glucose levels. There could be a number of different causes for a behavioural problem like this: it may be normal behaviour, or due to a psychiatric behavioural disorder, autism, mood disorders, anxiety or a physical disease.

Conduct Disorder is a chronic behavioural condition in which the child violates the rights of others repeatedly via aggression, theft and rule breaking<sup>6</sup>; Oppositional Defiance Disorder is a condition whereby children display hostile and defiant behaviour towards authority figures<sup>6</sup>; Attention Deficit Hyperactivity Disorder is a condition that consists of inattentiveness, hyperactivity and impulsivity, with a hyperactive subtype, an inattentive subtype, and a combined subtype<sup>6</sup>. Diagnosis can be made using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) criteria, or the

International Classification of Diseases 10<sup>th</sup> edition (ICD-10) criteria, but because the ICD-10 only recognises a severe type of ADHD called hyperkinetic disorder<sup>7</sup>, I shall use the DSM-IV-TR criteria in this essay. Diagnosing these conditions can be very difficult because they represent the extreme end of a spectrum of normal childhood behaviours<sup>8</sup>; it is made even harder by the fact that these conditions often co-exist, with one study demonstrating that half of children diagnosed with ADHD also suffer from CD or ODD<sup>9</sup>. Poor childhood behaviour may also be due to the inflexible behaviour patterns that are symptomatic of autistic spectrum disorders, learning disabilities, due to mania or depression, or as part of an anxiety disorder. Physical health problems such as absence seizures and hearing difficulties can also present with poor behaviour. CD, ODD and ADHD are the most prevalent causes of behavioural presentations<sup>1, 2</sup> and so I will focus on these disorders during this essay.

### **Epidemiology**

Behavioural problems are the most common reason for referral to the Child and Adolescent Mental Health Services (CAMHS)<sup>1</sup>. The combined prevalence of CD and ODD is 7.5% in boys, and nearly 4% in girls<sup>1</sup>; ADHD affects 3.62% boys and 0.85% of girls<sup>2</sup>. The apparent prevalence for these disorders has also increased dramatically in the last few decades, as indicated by the increase in diagnoses: the prevalence 30 years ago was 0.5 in 1000<sup>10</sup>. The apparent prevalence also varies between different continents; in South America it is 12% for ADHD<sup>11</sup>.

These disorders may not only be restricted to childhood: CD and ODD are strongly associated with adult anti-social personality disorder<sup>1</sup>, whilst 30-50% of children with ADHD will still have this condition as adults<sup>12</sup>.

### **Aetiology and Pathophysiology**

Environmental risk factors have strong associations with these behavioural disorders: maltreatment, sexual abuse and generalised adversity (a combination of poverty, poor parental marriage, parental criminality and parental ill health) are associated with ODD, CD and ADHD<sup>1, 8, 13-15</sup>. In addition, poor parenting is a significant cause for these conditions: there are associations with neglect and the sub-standard management of offspring's behaviour<sup>1, 16, 17</sup>.

B had some of these risk factors: the middle child in a family of five to an unemployed single mother, his family struggled for money and were in danger of losing their home. The CAMHS team noted that B's mother had very poor parenting skills: she struggled to discipline her children and complained to others about the inconvenience of B's diabetes and behaviour in front of him. B still had contact with his father, who was easily angered and could be violent.

The aetiology of ADHD has been found to be more complex and multi-factorial than the known causes for CD and ODD, and it can be considered a neurodevelopmental disorder as well as a behavioural problem. Adoption and twin studies have shown that ADHD has a genetic component<sup>18-19</sup>. The genes involved code for constituents of the dopamine pathways in the brain: there is evidence for the involvement of the receptors DRD4 and DRD5<sup>20</sup>, and the transporter DAT1<sup>21</sup>, however these genes are neither a necessary nor sufficient cause for ADHD<sup>22</sup>. Other environmental factors, such as in-utero smoke and alcohol exposure<sup>23, 24</sup>, zinc deficiency and lead exposure<sup>25</sup> are additionally associated with this disorder. Evidence now suggests that it is combinations of these genetic and environmental risk factors that have the highest associations with ADHD, such as the DAT1 gene and in-utero smoke exposure<sup>26</sup>.

There is some postulation as to why the genes that are associated with ADHD have survived natural selection: the hunter vs. farmer theory suggests that the symptoms of ADHD (hyperactivity, inattentiveness and impulsivity) produce humans who are hyper-vigilant and aware of their surroundings, and therefore make excellent hunters<sup>27</sup>. These characteristics have only become detrimental in the past few hundred years as society began to favour those who can concentrate and plan<sup>27</sup>. Anthropological studies have demonstrated a higher prevalence of genes associated with ADHD in nomadic people compared to their settled counterparts, compounding the theory that these traits may be beneficial for certain lifestyles<sup>28</sup>.

The pathophysiology of behavioural conditions is incompletely understood: regarding ADHD, abnormalities in the release of dopamine have been postulated to interfere with a child's ability to delay gratification, which results in inattention<sup>29, 30</sup>. In addition, imaging studies have demonstrated a reduction in size in parts of the brains associated with self control, attention and reward processing<sup>29</sup>. Similar evidence is lacking in CD and ODD, and this may be because behavioural disorders are social disorders more than they are medical conditions: social construct theory is the concept that behavioural disorders are not diseases, but society views them as such as an explanation for why certain individuals don't behave in a manner congruent with our norms<sup>3-5</sup>. Different societies determine what is normal and abnormal based on their own values: therefore according to this theory, behavioural disorders are more commonly diagnosed in societies where passivity is encouraged, whereas in other subcultures such as inner cities, the characteristics of these disorders such as aggression may be beneficial<sup>31</sup>. This may explain in part the apparent discrepancy in ADHD prevalence in different countries.

### **Diagnosis**

The National Institute for Health and Clinical Excellence (NICE) have produced guidelines on ADHD, which form the most complete UK guidance on the diagnosis and management of behavioural disorders<sup>8</sup>. The NICE technology appraisal on parent training for CD and ODD also provides further instruction<sup>1</sup>. They recommend that a diagnosis for a behavioural disorder be made in secondary care by a child psychiatrist or paediatrician after they have conducted a clinical interview, examined the child to exclude a physical cause for their behavioural disorder, and ratings scales such as the Connors scale or Child Behavioural Checklist have been used to help gauge the severity of the problem<sup>1, 8</sup>.

B was referred to CAMHS when the community paediatricians he saw regarding his diabetes could not decide upon a diagnosis for his behavioural problems. At school, B was in a Special Educational Needs (SEN) class due to dyslexia. His behaviour was very poor: he was violent towards students and staff, frequently ran out of class, shouted and swore daily, and had difficulties linking consequences to his actions. As a result of his poor behaviour and violence, he had few friends. At home he regularly fought with his older brother of 16 which caused much distress for his mother, and he had difficulties getting to sleep. He had problems understanding danger, and would run out into the road without looking. In addition, his diabetic control was poor because he would impulsively steal and consume sweets and chocolates from his mother. There was no family history of any diagnosed behavioural problems, but B's older brother also demonstrated some deviant behaviour.

On observation in the clinic, B was a distractible child who was constantly running around with his siblings, but unlike them he could not be calmed down. B did not feel he had any behavioural problems, but said he felt different due to his diabetes. Physical examination revealed no further disorders.

Following several sessions with CAMHS, B was diagnosed with severe combined ADHD: the other main differential was of behavioural problems due to poor blood glucose control. B has quite typical ADHD behaviours: he has poor behaviour at home and school, is very impulsive, hyperactive, and inattentive, and he performs poorly academically. B's mother was also diagnosed with depression due to his difficult behaviour, which is common in the parents of ADHD sufferers<sup>32</sup>.

### **Management**

The management of behavioural disorders in the UK is by therapy and educational interventions; for severe ADHD, medications are also recommended<sup>1, 8</sup>. The therapy consists of cognitive behavioural therapy, parental training, social skills training or family therapy. In cognitive behavioural therapy, the children learn how to plan tasks and to associate rewards with hard work. Parental training teaches people how to use techniques to appropriately manage their child's behaviour: this increases their confidence and the parent-child relationship, and has been proven effective for children with conduct and oppositional defiance disorders<sup>1</sup>. Social skills' training

teaches children how to behave in a socially appropriate way, allowing the children to maintain friendships and learn coping skills. Family therapy is used to identify and promote reflection on relationship difficulties if a child's behavioural problem is one manifestation of obvious family dysfunction. Structured home recreation and relaxation training are also recommended.

Children with behavioural disorders should have educational interventions to aid their learning: B continued in his SEN class and also had help from a teaching assistant. Simple measures like placing the child near the teacher to avoid distractions and repeating instructions are advised by NICE<sup>8</sup>.

Three medications are approved for managing severe ADHD: methylphenidate, dexamfetamine and atomoxetine<sup>8</sup>; these medications work by improving executive function and motivation. The first two drugs are stimulants, and atomoxetine is a selective noradrenaline reuptake inhibitor. The pharmacological action for these drugs is incompletely understood, but methylphenidate is supposed to affect the dopamine pathways of the brain<sup>29</sup>. Methylphenidate or atomoxetine are the first line medications<sup>8</sup>: B was commenced on modified release methylphenidate following his diagnosis, because of the severity of his ADHD symptoms. All three approved medications are controlled drugs and the main side effects are growth reduction, mild increases in pulse and blood pressure, and sleep disturbances.

### **The Benefits of a Child Psychiatric Diagnosis for a Behavioural Disorder**

There are a number of benefits accrued by a child, their family and society as a whole when a child with a behaviour problem is given a psychiatric diagnosis. Firstly, there is recognition by the medical community that the child's behaviour is abnormal, and interventions can be put in place to improve this. This may then help the child to have a better childhood and adult life. Finally, if a disruptive, poorly behaving child has interventions to help them improve their behaviour, this will benefit all the children in their class at school.

### **Recognition of the Problem**

B's mother found it helpful to know there was a cause for her son's poor behaviour, and having professionals acknowledge that there is a problem may be very beneficial for some parents. NICE recommends giving families accurate information on the child's condition<sup>9</sup>, which will help dispel any myths about behavioural disorders, and allow the parents to plan how to manage their child's behaviour. In addition, the diagnosis will be adopted into the way a child views themselves; this will help them to understand why they behave differently to other children<sup>33</sup>.

### **Interventions**

Following a diagnosis with a behavioural condition, many interventions will be made to the child's lifestyle that will benefit themselves and their families. Access to parent training classes teaches the parents to control their child's behaviour more effectively: their improved skills should also benefit any siblings. Therapy for children should allow them to have better self-control and responsibility for their actions, and help them to socialise and cope with school better. If the child requires pharmacological treatment, this will aid their concentration and help improve their behaviour. For BN, starting treatment significantly improved his performance at home and school.

### **Improvement in Lifestyle**

Behavioural disorders can cause many problems for children; they reduce academic performance, their ability to make friends and their mood<sup>32, 34, 35</sup>. If these disorders carry on to adulthood as an anti-social personality disorder or adult ADHD, the individuals are more likely than their peers to be involved in crime, abuse drugs and alcohol, and suffer from mood disorders<sup>1, 36</sup>; one study stated that almost half of inmates in prison would have fulfilled the diagnostic criteria for ADHD as children<sup>37</sup>. It stands to reason that by modifying the child's behaviour before serious criminal behaviours develop, sufficient improvement can be made in functioning to improve the employability and quality of life for these individuals. Improving their behaviour may also be beneficial for the child's physical health: B's diabetes was very poorly controlled due to his

impulsivity and tendency to eat unhealthy foods, but once he commenced methylphenidate his diabetic control improved.

The health of the parents and overall family harmony may also be enhanced: it is common for parents of children with behavioural disorders to have marital strife and develop mood disorders<sup>32</sup>, so an improvement in the child's behaviour could alter this. The parents would also have more time to spend with any other siblings.

### **Benefits to the Wider Society**

As demonstrated by B's case study, children with behavioural disorders can be very unruly in class, demanding a lot of time and attention from the teacher and disrupting the other students. By improving the behaviour of these children, all the students in the class will be able to benefit; this should help the students in the SEN classes even more so, as they require the most help.

The overall cost to society may be reduced by managing behavioural problems in childhood. As mentioned above, these disorders predispose children to becoming criminals: treating the child for a behavioural problem would be substantially cheaper than the cost of their imprisonment as an adult.

### **The Detriments of a Child Psychiatric Diagnosis for a Behavioural Problem**

ADHD, CD and ODD are controversial diagnoses amongst medical professionals, educators and the lay public. For a child diagnosed with ADHD, the validity of the diagnosis may be brought into question by others who may feel the parents are trying to obtain an excuse of not disciplining their child, or medication to improve their performance at school, as certain factions of the media may suggest<sup>38-39</sup>. As a result, a diagnosis like this can bring stigma. There are additional ethical issues that must be considered surrounding medicating children with strong behavioural modifying drugs. Finally, the expense to society for the management of these conditions must also be acknowledged.

### **Validity of Diagnosis**

There is much controversy amongst the medical profession and lay public about the validity of behavioural disorder diagnoses. As mentioned above, some sociologists believe that behavioural disorders are a way for societies to explain why not all children act in a way conforming to their norms and values<sup>3-5</sup>. Therefore, the prevalence levels for these disorders vary between societies depending on their tolerances for poor behaviour: this is evidenced by a diagnosis of ADHD being 3-4 times more likely using the mainly American DSM-IV-TR criteria rather than the mostly European ICD-10<sup>22</sup>.

NICE considers ADHD to be a valid medical diagnosis<sup>8</sup>, but does address that the diagnostic criteria lack the integrity that they should: they do not qualify some of their terms which are very open to interpretation, such as "some impairment from the symptoms is present in two or more settings"<sup>6, 8</sup>. The criteria also approach behavioural disorders as a dichotomy between normal and abnormal behaviour, rather than as a spectrum of behaviour where a pathological cut-off must be determined<sup>40</sup>. The validity of the diagnosis is also questioned by the apparent increases in prevalence over time, which are due in part to increased awareness of the disorder, although it has been questioned whether this fully accounts for this phenomenon<sup>8</sup>. Because of the severity of his symptoms, B's diagnosis has never been doubted. However for children who have milder symptoms, people may examine the accuracy of their diagnosis because it is difficult to distinguish behavioural disorders and normal boisterous childhood behaviours<sup>8</sup>.

Categorising and diagnosing children with behavioural problems may be convenient for societies to help maintain their status quo, but this will have negative impacts on children whose diagnosis is questionable. Labelling theory is the idea that when diagnosed with a psychiatric condition, people will incorporate this label into their identity and start behaving in a manner appropriate to this<sup>41</sup>. Therefore, by incorrectly diagnosing a child with this condition, a self-fulfilling prophecy is

created as the child learns about the symptoms and thinks this is the way he should behave, resulting in a spoiled identity<sup>41</sup>.

As a result of the difficulties over diagnosis, certain factions of the media have helped to fuel the controversies surrounding ADHD. Newspaper articles with pejorative titles such as “Naughty child syndrome costs taxpayer £170m”<sup>38</sup> and “Chemical cosh boom: demand for ADHD drugs soars 70% in 5 years”<sup>39</sup>, question the validity of psychiatric diagnoses for behavioural problems, and focus on people abusing the diagnosis for medication and benefits.

### **Subversion of the Sick Role**

A correct or incorrect diagnosis with a behavioural disorder may be abused by some individuals for their own gain. For a parent with poor disciplining skills, a diagnosis with a “disorder” removes the association between the child’s bad behaviour and the guilt they should feel about their parenting<sup>42</sup>. If anyone questions their child’s behaviour, they could blame it on the disease, and even though they will be offered ways to improve their skills, they may prefer simply to have a diagnosis and an excuse, and perhaps even a medication to correct this. Teachers may collude with parents in this manner of thinking because having a poorly behaved child makes a whole class harder to teach than a quiet, medicated child<sup>42</sup>.

In addition, parents may wish to commit benefit fraud by claiming their child has a medical condition: it would be much easier for the parents to pretend that their child has a behavioural disorder than a physical disorder where a thorough examination and investigation could prove otherwise. Finally, parents may also benefit from a misdiagnosis of a behavioural condition because the medications used to treat ADHD are so non-specific: they will improve motivation and executive functioning in all children, not just those suffering from a behavioural disorder. To improve their child’s performance at school, parents try to convince a doctor to prescribe them medication. For these reasons, parents may lie about or exaggerate their child’s symptoms.

The child may also have their own reasons for subverting the sick role: by having a disorder, they may be given more allowance for bad behaviour<sup>42</sup>. For a child with poor behaviour like BN, they may feel that if they had a diagnosis for a behavioural problem, they could use it as an excuse for not being punished in school or at home.

Ultimately, subversion of the sick role is not beneficial for society. It may be helpful in the short-term for some families, but it increases the disrepute of a diagnosis of ADHD, may lead to spoiling of a child’s identity, and will cost the NHS to manage these children.

### **Stigma**

A diagnosis of a psychiatric condition for a behavioural disorder may be detrimental to a child and their family due to stigma: stigma is a common consequence of psychiatric diagnoses<sup>43</sup>, and may be worse in behavioural disorders due to the excessive media coverage of these conditions, and concerns over families subverting the sick role. B already suffered from stigma due to his diabetes, and did not notice an increase when he received his ADHD diagnosis; B’s mother also experienced no stigma related to the ADHD diagnosis. However, experiences for other people are very different.

In a study of 48 parents of children with ADHD, 77% had experienced stigma surrounding the symptoms and the diagnosis, and 44% were concerned with how their child would be labelled<sup>44</sup>. Studies on children’s attitudes to ill health have shown that there are more negative feelings towards children with ADHD than children with asthma<sup>45</sup>. American adolescents with ADHD regretted telling peers about their diagnosis and felt it should be kept a secret<sup>46</sup>. These high levels of real and perceived stigma demonstrate that a diagnosis with a behavioural disorder may be detrimental to the way a child and their family are viewed.

### **Concerns Regarding Treatment**

For B, taking methylphenidate improved his behaviour and academic performance. However, the effects wore off by the evening and therefore putting him to bed was still difficult: ADHD medications are not a cure and provide only temporary relief from symptoms. In addition, the benefits of these medications for children may be less than hoped for, as they do improve academic abilities in the short term, but no long term benefits on school performance have yet been proven<sup>47</sup>.

In addition, here are ethical issues surrounding taking these medications: parents may feel they are suppressing their child's true personality<sup>48</sup> and corrupting their innocence by giving them powerful drugs<sup>22</sup>; there are concerns that the medications have not been tested thoroughly enough in children<sup>49</sup>; and, if children refuse to take their medications, their parents may have to force them or trick them into consuming the drugs. As a result of these problems, some children may not be taking their treatment, meaning they still have the behavioural problems that will adversely affect their lives; other children will then suffer as their parents and teachers are excessively occupied with the children with ADHD. Furthermore, these drugs are controlled substances, and the potential for abuse or for selling these medications to others is detrimental to society.

Also, management for behavioural disorders may be sub-optimal due to a lack of protocols regarding this. Children with behavioural problems are treated by either paediatricians or CAMHS, with CAMHS usually managing the more complex cases. However, in Leicestershire at least, I have been informed that the paediatricians cannot refer to statutory therapy very easily, and must refer children to the voluntary sector. These schemes may not have the same validity as NHS run treatment centres, and they are dependant on donations to run: this could result in care that does not reach the NICE guidelines. If children are not receiving the recommended management, their poor behaviour will still adversely affect them, their families and the wider society.

### **Economic Cost to Society**

Treating behavioural conditions, like the management of all medical problems, is costly. ADHD alone costs £23 million yearly in initial assessments in secondary care, and £14 million for follow ups, whilst the medications cost £29 million yearly<sup>8</sup>. With the increase in diagnosis of ADHD, and the change to more expensive long acting medications, the costs may rise further still. These figures do not cover the cost of therapy, or the benefits some families may receive.

### **What can be Done to Improve the Lives of Children with Behavioural Problems?**

As this essay has demonstrated, behavioural conditions can be costly to society and devastating for the children and families involved regarding their quality of life, social interactions and academic achievements. There is also a great deal of controversy around these diagnoses, and therefore I have decided to review material found in the literature and my own ideas on how to improve the lives of these children.

### **Prevent Behavioural Disorders**

The first step in improving the lives of children with behavioural conditions would be to reduce the incidence, by tackling known risk factors, such as in-utero smoke exposure and poor parenting. Advice is already given to expectant mothers about smoking during pregnancy, but I think that explaining the association with ADHD may provide women with another tangible reason to quit.

When a child is presented with a behavioural problem in primary care, the first line of management is referral for parenting behavioural classes<sup>8</sup>. If parenting classes were given as part of ante-natal and post-natal care in the UK, this would allow parents to learn the skills they need to effectively bring up children and improve the standard of UK parenting: it stands to reason that behavioural disorders in children would then decrease, due to the strong associations between parenting and these conditions<sup>1, 8</sup>. For example, if B's mother had learnt to parent him effectively from a young age, he may still have had ADHD but his difficult behaviour would be reduced due to effective early parental intervention.

### **Improve the Diagnostic Criteria**

There is a great discrepancy in the apparent prevalence rates of behavioural disorders, in particular of ADHD<sup>14</sup>, and also between the diagnostic guidelines of the ICD-10 and DSM-IV-TR. To improve this, the ICD-10 may wish to adopt guidelines that are more similar to their American counterpart, as ADHD is so widely recognized now by the psychiatric community. The DSM-IV-TR then needs to provide more specific diagnostic criteria, with examples to qualify some of the terms they use to make the diagnosis more standardised<sup>40</sup>. A dimensional rather than dichotomous approach needs to be adopted, viewing the disorder as one part of a behavioural spectrum<sup>40</sup>. Emphasis also needs to be placed on reviewing the diagnosis, because in three years time half of ADHD children no longer fulfil the diagnostic criteria<sup>50</sup>. Finally, it must be recognised that behavioural disorders are social disorders just as much as they are medical problems: when NICE wrote their ADHD guidelines they had sociologists on the team, and it would also be beneficial to emulate this when writing the diagnostic guidelines<sup>22</sup>. If these changes were made and the criteria improved, then the prevalence rates for these conditions would hopefully become more consistent, producing a more reliable diagnosis and thus reducing some of the controversy and stigma surrounding the condition.

### **Improve Teachers' Awareness of Behavioural Disorders**

B is fortunate in that his school has been able to provide good help and support for his learning needs. However, research suggests that teachers have insufficient knowledge about behavioural disorders and their management<sup>51</sup>. NICE acknowledges the very important influence that teachers have on the lives of children with deviant behaviours<sup>8</sup>, and the National Service Framework has identified the need for teachers to be more knowledgeable about conditions adversely affecting education<sup>52</sup>. Educational interventions make up a significant part of the management of these children, and therefore teachers should be made more aware of behavioural disorders, their impact on education, and the best ways to instruct these children.

### **Improve Multi-Agency Working**

Medically, behavioural disorders are managed by paediatricians or the CAMHS team. As mentioned earlier, the paediatricians are limited in their ability to refer children for therapeutic interventions, resulting in management that may not reach the NICE recommendations. For B, it took several years to get a diagnosis because he was seen by the paediatricians initially before he was referred to CAMHS and given treatment. Quicker inter-agency referral and management may have meant he improved his behaviour and academic performance at an earlier stage. Making protocols and guidelines regarding who has responsibility for children with behavioural disorders should improve the speed of diagnosis and management for these conditions.

### **Conclusion**

Behavioural disorders such as CD, ODD and ADHD are prevalent conditions that will lower a child's quality of life, and may continue into adulthood causing difficulties with employment, substance misuse and mood disorders. For children like B, a 14 year old boy with poor impulse control issues and violent and disobedient behaviour, diagnosis with one of these conditions has provided a mixture of benefits and detriments. The NHS must pay for diagnosis and treatment of what are essentially social disorders, whilst the children and their families may experience social stigma due to this label. However, families will receive help and interventions that will benefit the child, and which should have a subsequent beneficial effect on the whole family and society. Children with behavioural problems need help; the CAMHS team have the knowledge and abilities to help them, so it makes sense that they should be managed by this service, along with effective educational interventions. However, what would be most beneficial for society would be to reduce the incidence by targeting and preventing modifiable risk factors, rather than waiting for them to manifest as behavioural problems.

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## Child and Family Education Editorial Board (CAFPEEB) Survey Results

Last year, CAFPEEB sent a survey to all Child and Adolescent Faculty members via its newsletter and to the FOCUS email group asking for feedback and comments on child and adolescent mental health leaflets on the College's website. We received 108 responses. Here is a summary of the results and some very helpful comments and suggestions.

The majority of respondents had positive comments on the College's information for parents, teachers and young people. The College is the most used website for accessing mental health information, followed by local trust websites and Young Minds.

According to survey, the top ten most frequently accessed information leaflets were:

- Depression
- ASD/Autism
- Eating disorders
- Stimulants
- CBT
- ADHD
- OCD
- Worries and Anxiety
- Psychosis
- Self harm

Respondents also highlighted some areas of development and the need for information on:

- medications used in child mental health;
- tics/ Tourette's Syndrome;
- attachment disorders and adoption;
- emerging Personality Disorder;
- challenging behaviour;
- information for CAMHS learning disability population.

We received helpful suggestions on improving existing information and on receiving feedback. About 40% of respondents were interested in contributing to updating the leaflets. We have taken on board the comments made in updating the most popular leaflets. We have created a database of those respondents who expressed an interest in helping CAFPEEB to update the information on regular basis.

We would like to thank all members who responded to the survey and would welcome suggestions and feedback on any leaflets on website via the feedback form at the end of each factsheet.

## **The Child and Maternal Health Observatory (ChiMat)**

### **Data and other resources to improve CAMHS**

The Child and Maternal Health Observatory (ChiMat) was established in 2009 as a specialist public health observatory with funding from the Department of Health. Its aim is to provide a range of freely available resources to give those working in the field the data and evidence they need to make informed decisions and improve children's and maternity services.

Over the past year, ChiMat has placed significant emphasis on increasing the tools and data it provides which look at child and adolescent mental health and psychological well-being, with two main focuses for its work.

#### **Extended range of freely available tools and data**

ChiMat has extended the range of freely available tools and data which save you and your organisation valuable time and allow you to carry out more detailed analysis locally based on initial findings. There is also now a complete network of local specialists working across the country who offer health intelligence expertise, advice and support in using data and evidence either by email, over the phone or in person:

- The Outcomes versus Expenditure Tool – CAMHS compares expenditure and other aspects of services with a number of outcome measures at primary care trust (PCT) level. It allows you to pinpoint opportunities to improve the **quality of outcomes** and **productivity** for services in your local area.

- The Needs Assessment Report – CAMHS gives information about **prevalence, incidence** and **risk factors** and supports the development of children's and young people's planning and joint strategic needs assessments.
- The Service Snapshot – CAMHS presents data which describe the way your **current service** and **workforce** are structured. It also looks at **demand** for CAMHS in your local area.
- Data Atlas brings together a range of **data** and **statistics** on child health and produces charts and maps which show comparisons with other areas for key indicators.
- There are two self assessment tools available to help CAMHS partnerships to **assess progress against mental health and psychological well-being standards**. One looks at CAMHS and the other at young people's mental health transitions.
- The Comprehensive CAMHS Integrated Workforce Planning Tool provides a step-by-step guide to developing your **local workforce plan** and includes example workforce plans from pilot sites.

### **Developing the knowledge hub and providing ongoing access to National CAMHS Support Service (NCSS) resources**

Over the past year, ChiMat has worked closely with NCSS to make its resources available on the ChiMat website. The NCSS programme came to an end on 31 March 2011 but you can still use its valuable resources as part of the children's mental health and well-being knowledge hub.

We continue to work in partnership with Young Minds to bring together the latest reports, information, evidence, policy and good practice about child and adolescent mental health.

The knowledge hub covers many topics including commissioning for children's mental health, CAMHS workforce, participation and tackling stigma.

To complement the knowledge hub, you can sign up to receive regular eBulletins which signpost the latest information resources, initiatives and organisations to keep you up-to-date. The following eBulletins are available:

- ChiMat knowledge update on children's, young people's and maternal health (weekly eBulletin);
- Mental health and psychological well-being produced by NCSS in partnership with YoungMinds (monthly eBulletin);
- Learning disabilities and CAMHS (monthly eBulletin);
- Perinatal and Infant Mental Health (PIMH) (monthly eBulletin).

To use ChiMat's tools and other resources, visit [www.chimat.org.uk/camhs](http://www.chimat.org.uk/camhs)

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## Psychodynamic Psychotherapy for Child and Adolescent Psychiatrists

### The Tavistock and Portman NHS Foundation Trust

This course is aimed at child and adolescents psychiatrists with an interest in psychodynamic psychotherapy. The course is designed as a series of units which can be taken together, or built up gradually. Trainees can undertake the clinical work in their own setting or at the Tavistock Clinic. Units begin at the start of the academic year in order to have a peer group, but exceptions can be negotiated.

#### Aims

- a. To enable child and adolescent psychiatrists with an interest in psychodynamic psychotherapy to expand and develop their practical skills.
- b. To provide an opportunity to study relevant psychoanalytical concepts and to link these with ways of working in different clinical settings.
- c. To provide child and adolescent psychiatrists with a qualification that leads to membership of the Tavistock Society of Psychotherapists.

#### FURTHER INFORMATION

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Email: [edpsychadmin@tavi-port.ac.uk](mailto:edpsychadmin@tavi-port.ac.uk)  
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## Charity Fears for Family Services

### Action for Children – Recent Report

Disadvantaged and vulnerable families are at breaking point and services set up to support them are struggling to cope, a charity has warned. Action for Children said a mix of problems including substance misuse, government spending cuts and unemployment are leaving thousands who are in urgent need unable to get help.

Following a year long investigation Action for Children warned:

- 68% of frontline children's services have had cuts to their budgets and over a third (37%) of these services have seen cuts of between 11% and 30% this year alone.
- In the last three months, 48% of frontline services have reported a "marked rise" in the number of children, young people and families needing a service but unable to access one.
- At least 5,000 vulnerable children, young people and families have been identified as needing the services Action for Children provides but are currently not receiving them.

The charity said more than half of its frontline services – including children's centre's, disabled support and help for young carer's – have reported an increase in users facing more severe problems than they did six months ago.

Managers believe demand for their services has risen because of an increase in: family breakdown (41%), parental mental health/physical health issues (39%), reduction in other community services such as child and adolescent mental health services (38%), reduction in household income because of unemployment (26%) and benefits reduction (22%).

## **Mind the Gap Meeting – Very Difficult Behaviour in Children with Epilepsy**

**8<sup>th</sup> March 2012 - London**

Professor Brian Neville and the National Centre for Young People with Epilepsy invite you to attend the third "Mind the Gap Meeting" about "Very difficult behaviour in children with epilepsy", which we think will be of interest to all concerned with the management of childhood epilepsy. The first two meetings were very successful.

**Date: Thursday 8 March 2012**

**Venue: Kennedy Lecture Theatre, UCL-Institute of Child Health, Guilford Street, London, WC1H 1EH**

The speakers include; Christopher Gillberg, David Taylor, Eric Taylor, Philippa Russell, Heather McAlister, Mike Kerr and Brian Neville.

More details, including a copy of previous reports and booking forms will be available shortly from our website: [www.ncype.org.uk](http://www.ncype.org.uk)

To register an interest, please email [info@ncype.org.uk](mailto:info@ncype.org.uk)

Spaces are limited and will be reserved on a first come, first served basis.

## **Ofsted Reports on the Protection of Vulnerable Babies and Young People**

### **Ages of Concern and Edging Away from Care: Published October 2011**

In October Ofsted published two reports highlighting the vulnerability of teenagers in the child protection system; Edging Away from Care and Ages of Concern.

Ages of Concern: Learning Lessons from Serious Case Reviews highlights key lessons learnt over the last four years from reviews of serious incidents involving either babies under one year old or children over 14.

For babies less than one year old, there were shortcomings in timeliness and quality of pre-birth assessment. The cases reviewed showed repeated examples of agencies underestimating the risks for children arising from their parents' background and lifestyle, whether they related to drug or alcohol misuse, a past history of being looked after, abuse during their childhood or being a victim of domestic violence as an adult. There was also inadequate support for teenage parents who should have been considered as children in need in their own right.

For children aged 14 and over cases reviewed showed the complexity and range of risks teenagers face including alienation from their families, school difficulties, accommodation problems, abuse by adults, unemployment, drug and alcohol misuse, emotional and mental health difficulties and domestic abuse.

The report found a wide diversity of incidents that resulted in the SCRs for teenagers, with no clear patterns. However, lessons can still be learnt. Common messages from the reviews analysed were: agencies focused on the young person's challenging behaviour, seeing them as hard-to-reach or rebellious, rather than trying to understand the causes of the behaviour and the need for sustained support. Young people were treated as adults rather than children, because of confusion about their age, their legal status or availability of age-appropriate facilities, especially for those aged between 16 and 18. There was no coordinated approach to meeting young people's needs and practitioners had not always understood the important contribution of their agency in achieving this.

Ofsted also published **Edging away from care – how services successfully prevent young people entering care**. This report looks at the good practice of 11 local authorities who are taking measures to help ensure that only those young people who need to, come into care. The authorities were committed to working 'safely' to reduce their numbers of looked after children and to manage the risks associated with helping young people to remain living with their families and communities.

## **Transitions in Mental Health Services for Young People: A Practice Guide**

### **Social Care Institute for Excellence (SCIE)**

The Social Care Institute for Excellence's (SCIE) practice guide on **Transitions in mental health services for young people** will be launched on the 28<sup>th</sup> November.

SCIE have produced a research briefing and a number of case studies which can be found on their [webpage](#). The practice guide and at-a-glance guide will also be added to this page from 28<sup>th</sup> November.

## Why do people with mental disorders die younger and what can be done about it?

### Royal Society of Medicine (RSM) conference

'Why do people with mental disorders die younger and what can be done about it?' will be held on Tuesday 13 March 2012, at 1 Wimpole Street, London W1G 0AE. The conference is relevant to all psychiatrists with talks on obesity, identifying people with acute illness, and resources for improving physical health care.

<http://www.rsm.ac.uk/academ/pyc05.php>

### Congratulations.....

Dr Helen Bruce, Consultant Child Psychiatrist at Barts and the London Hospitals, and a Programme Director for the GOS/London Higher Training Scheme in CAP in London, has been awarded a national teaching fellowship by the Higher Educational Academy. These fellowships which come with a £10,000 prize recognise excellence in teaching or learner support.

### Are your membership details up to date?

You can update your personal details via the Members' Area of the website. By ensuring that your details are up-to-date on our database, you will receive the latest information regarding topical news, updates from your local Division and information from the Faculties, Sections, and SIGs that you belong to. In the Members' area, you can update your postal and email addresses, Faculty, Section and SIG memberships, job title and the area of psychiatry that you are working in. If you have not yet registered a username and password, or have forgotten your login details, then please follow the same link for more information. You can also update your membership details by post, by email or contact the Membership Data Office on 020 7235 2351 (extensions 6281 or 6280).

### Your contributions to this Newsletter are welcome!

Please send any contributions for the next newsletter, which will be published in April 2012, to the email address below by the end of February.

**Kay.Harvey@cht.nhs.uk**

## **Contacts...**

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## **The End**

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