

RCPsych awards 2019

RCPsych are now accepting nominations for the 2019 RCPsych Awards.
Closing date for entries - 12 April 2019



Adolescent Forensic Psychiatry webpage

Information, resources, previous minutes and newsletters



SPRING 2019 NEWSLETTER

**ADOLESCENT FORENSIC PSYCHIATRY
SPECIAL INTEREST GROUP**



DEAR ALL AFPSIG MEMBERS

*HEIDI HALES, AFPSIG CHAIR,
CONSULTANT ADOLESCENT FORENSIC PSYCHIATRIST
NORTH WEST LONDON FCAMHS, WEST LONDON NHS TRUST
E: HEIDI.HALES@NHS.NET*

Happy 2019.

As I write this in snowy and blowy weather, there continues to be much to be hopeful about, with the ongoing development of FCAMHS and Secure Stairs services and the publication of the 10 year NHS plan. Brexit continues to take up government time and dominate the news. Our work in AFPSIG continues. In November we had a very successful AFPSIG study day on Gangs and Grooming. Many thanks to Peter Misch and Holly Wolton for helping to arrange the day. Holly Wolton (our new ST rep on AFPSIG exec) describes the highlights below. Alongside this, Tina Irani has been our representative on an expert group updating the Healthcare Standards for Children and Young People in Secure Settings. This is now being finalised and will be published in due course. Discussions continue on the issue of solitary confinement and restraint in young people in security.

We will have our AFPSIG update meeting at the Forensic Faculty meeting in Vienna on Thursday 7.3.19, do come. We have had several ideas about future study days and evening events, working with other faculties and SIGs in our college. If you have any ideas of events you would like to arrange through our AFPSIG, then please get in touch. We will discuss further in our meeting on 7.3.19 but just to note that our current thoughts are that the topic for this year's annual study day will be about the difficulties young women face. If anyone is interested in helping to arrange this, do get in touch.

CALL FOR AFPSIG MEMBERS TO STAND FOR CHAIR OF AFPSIG.

My 4 year stint as chair of AFPSIG comes to an end in the summer. I have very much enjoyed my time and learnt a lot. We have missed this year's RCPsych election round and so the election for will be in Summer 2020. For this year, the AFPSIG executive will co-opt someone to cover the chair role. So, if you are interested in being co-opted this year, or to stand for chair next year, please be in touch. Also, if you are interested in working in the executive.

EXECUTIVE COMMITTEE

- | | |
|------------------------|--|
| HEIDI HALES | CHAIR |
| OLIVER WHITE | SPECIALIST TRAINING FORENSIC FACULTY LIAISON SECURE CAMHS CLINICAL ADVISORY GROUP |
| RICHARD CHURCH | EFCAP AND INTERNATIONAL LIAISON WEBSITE EDITOR |
| HOLLY WOLTON | SENIOR TRAINEE REP |
| PETER MISCH | MEDICOLEGAL |
| ENYS DELMAGE | INTERNATIONAL REP |
| ERNEST GRALTON | FORENSIC DEVELOPMENTAL DISABILITY |
| ALEXANDRA LEWIS | PRISONS REP |
| LAXMI KATHURIA | CO-SCOTTISH REP |
| AILEEN BLOWER | CO-SCOTTISH REP |
| WALEED AHMED | NEWSLETTER EDITOR |
| PHILIP ANDERSON | NORTHERN IRISH REP |
| DAVID KINGSLEY | FINANCIAL OFFICER, CHILD AND ADOLESCENT FACULTY LIAISON, CONSULTATION |
| NICK HINDLEY | COMMUNITY FORENSIC CAMHS |
| PAUL MONKS | INDEPENDENT SECTOR |



A STOLEN CHILDHOOD: GANGS AND GROOMING – 19/11/18 (A REPORT FROM THE CONFERENCE)

HOLLY WOLTON

ST4 CHILD AND ADOLESCENT SPECIALTY TRAINEE

The Annual Adolescent Forensic Psychiatry Conference took place on the 19th of November at the Royal College of Psychiatrists in London. It focussed on a topic which is of great interest not only for mental health professionals but also medical specialists, politicians and members of the public. The title of the conference was; ‘A Stolen Childhood: Gangs and Grooming’, which is a regular point of discussion in the news currently.

The one day conference included talks from; senior medics working on the frontline who treated victims of gang related violence, policemen and social workers working with these young people, and, the MP for Stockport, Anne Coffey. The day also included a presentation on research on how social media is being used by gangs and a fascinating and thought provoking talk by Ebinehita Iyere, who works for Peer Power and has personal experience of gangs.

We heard about new interventions that are being used in forensic services to help individuals who have been convicted of gang related offences. The day closed with a panel discussion about how we can work together to help young people who are involved in gangs, and reduce youth violence. The importance of a multi-agency approach was identified, as well as involving the families and communities as much as possible and universal parent training. Young people involved in these gangs wanted mental health services to be more approachable and accessible if they were trying to get out of a gang.

With over 100 attendees, the organising committee received positive feedback about the day and we hope that the conference has ignited further interest in this sub-specialty of psychiatry.



SCOTLAND UPDATE

DR AILEEN BLOWER

CONSULTANT FORENSIC ADOLESCENT PSYCHIATRIST

Whilst Scotland has gone quiet in this newsletter for the past 3 years, much has been afoot up north. Colleagues from other jurisdictions will be pleased to learn of the Bill to raise the Minimum Age of Criminal Responsibility in Scotland from 8 to 12 years. Efforts to further decriminalise children who “offend” continues to present interesting challenges to the reporting and management of harmful conduct in younger people.

Our 2017-27 mental health strategy includes several “Actions” of relevance to the prevention and management of high risk behaviours in children and young people. These range from parenting programmes for under 5’s, pathways for young people on the margins of secure care and development of highly specialist inpatient services. Plans for the first dedicated secure adolescent unit in Scotland are well underway, and we are ever grateful to support from colleagues from NHS England Forensic CAMHS Network for guidance and encouragement in this long term “project”.

Meantime, the Mental Welfare Commission for Scotland continues to identify a small but important number of young adolescent admissions to PICU and other locked adult wards. We also note the continuing movement of vulnerable young people across the British Isles to access care. Hopefully the situation will improve, as we see more impetus toward development of specialist inpatient care for under 18’s with acute psychiatric needs and/or learning disability.

Our regional networks support intensive home-based treatment which has improved access to the three generic adolescent units. However, the task of managing high risk patients in the community remains a challenge for hard-pressed Tier 2/3 CAMHS, as most areas have no dedicated Forensic services. With new clinical leadership in the West of Scotland, plans are being revived for regional FCAMHS provision. Exciting work has also been done around pathways, standards and outcomes for secure accommodation in Scotland.

Change is now being driven by a new Children and Young People’s Taskforce with wide-ranging remit to modernise mental health services for 0-24 year old’s across all sectors. A task indeed!

Hopefully fresh services will attract new recruits, and our education leaders have achieved a lot to develop the speciality higher training programme in Scotland. This includes reviving dual training in Forensic Child & Adolescent Psychiatry.

Like all AFPSIG members, Scottish CAMHS psychiatrists are kept busy with service development work in addition to demanding “day jobs”. This ancient medical skill was noted by our Mary Queen of Scots (1542 – 87): Just the actual physical ability to hold four instruments simultaneously and do some of the things that Vivien was able to do is mind blowing to any surgeon.



WALES UPDATE

DR JULIE WITHECOMB

CONSULTANT FORENSIC ADOLESCENT PSYCHIATRIST

FACTS WALES

Wales has had a national community Forensic Adolescent service for more than 10 years. The service has seen huge changes over the decade and, in the context of a strategic review, is potentially on the brink of further expansion and development.

The ‘core FACTS’, set up to support CAMHS by means of direct risk assessment of a small number of young people, continues to provide a service from dual centres in South and North Wales – although our population is small, there are significant geographical challenges in managing cases and a team across the country.

Over the last 4 years, FACTS has been developing an in-reach service to provide for the young offenders detained in Parc prison. Although the number of young people detained there is decreasing, challenges remain such as working across the legislative boundary with England and aiming to provide a more trauma and attachment informed service from prison officers as well as health staff.

Our most exciting current area of work, though, is the Enhanced Case Management project through which we are developing, with YJB Cymru, a model of psychological consultation to Youth Offending Services; the second clinical phase of this has just been completed and will be subject to independent review. We are hoping that this will be rolled out nationally across Wales in the next 12-18 months.



WORKING IN NEW ZEALAND AS AN ADOLESCENT FORENSIC PSYCHIATRIST

CONSULTANT IN ADOLESCENT FORENSIC PSYCHIATRY AND ASSISTANT PROFESSOR AT THE UNIVERSITY OF NOTTINGHAM | NGA TAIOHI AND HIKITIA | MENTAL HEALTH, ADDICTIONS & INTELLECTUAL DISABILITY SERVICE | TE-UPOKO-ME-TE-KARU-O-TE-IKA

“It’s the same but different”

I’ve been working in the national adolescent forensic inpatient service in New Zealand for the past year and thought I’d reflect a little for the UK Newsletter. So – I’ll tell you a bit about our service, rather than reflecting on the 28 hour flight from the UK with 2 children aged 1 and 0 respectively (actually not as bad as it sounds). Here in NZ, we have 10 secure beds (mixed gender) for children with mental disorders and 8 secure beds (mixed gender) for children with intellectual disabilities, covering the whole of New Zealand (population about 5 million). What you might expect, and you’d be correct to expect this, is that there are broadly similar mechanisms for getting people into hospital from the community, from courts and from prisons. There is a Mental Health Act and also an Intellectual Disability Compulsory Care and Rehabilitation Act. There is a welfare system free to all, and one branch specifically for children (“Oranga Tamariki”), who have their own Act. Everyone uses the SAVRY. We drive on the left and the sun rises and sets each day, albeit 12 hours earlier than in the UK.

There are 4 Youth Justice and 4 Care and Protection Residences providing 20-30 beds each (which are like LASCHs with YJ beds or welfare beds respectively), and are run by NZ children’s social services. We don’t have any YOIs or STCs as the YJ Residences meet that need. There are adolescent forensic community teams, we have Youth Offending Teams, and there are a number of NGOs that provide services for young offenders with mental health problems, purchased by the 20 District Health Boards in New Zealand. The country is well-known for its friendly “can-do”

attitude and this is something that you come across on a daily basis. Another refreshing reality is the economy-of-scale effect which means that the small number of adolescent forensic psychiatrists (there are about 15 of us, some of whom are part-time) end up doing some exciting political stuff, some edifying public health stuff and some laborious but interesting court stuff. There is also a great study budget and training is strongly encouraged. We have no Brexit or Trump, the economy is healthy, there's a surplus of sunshine and Fiji is 3 hours away if you're bored of the 12,000 foot peaks, fjords, waterfalls, glaciers, skiing and beachside barbecues in New Zealand.

So, I'm obliged to reflect on what could be better rather than continuing on my obvious recruitment campaign – we have approximately 33% fewer adolescent forensic beds per capita compared to the UK and the units I work on are not full, nor have we ever had a waiting list in the 2.5 years the units have been open. The socioeconomic conditions here are broadly comparable – New Zealand has its fair share of poverty, drug problems and crime. So - how is this possible? Well, essentially primary conduct disorder or mixed disorder of conduct and emotions is an exclusion criterion for admission to the inpatient adolescent forensic service. Sadly, these children aren't getting a great service in the community either – community CAMHS teams are pretty busy and don't have the capacity to provide the type of care these young people require, so they are frequently signposted to well-meaning but often ineffective NGOs who don't do risk management particularly comprehensively, are unable to deliver robust wrap-around therapies in a way that would be recognisable in the UK, and often have anaemic links with other agencies. HOWEVER – there are moves to address this issue and the recent Mental Health Inquiry Report has made some suggestions which may aid the cause. There is a huge national development opportunity in relation to children with conduct disorders and the experience from clinicians in the UK is invaluable in promoting early (?ultra-early) intervention, targeting families that are struggling, four year olds who are oppositional and aggressive and 10 year olds who are offending, using drugs and who are vulnerable. The adolescent forensic network is very supportive and receptive to suggestions, and there is an active focus on strategic service development (i.e. learning from experiences elsewhere in order to replicate the good bits and avoid the less good bits), which makes it an exciting place to work.

I'd thoroughly recommend the experience of working in a different country as it highlights different ways of working – the Family Group Conference is one good example (first used in Ireland) – this is an alternative to court, or may be directed at the first court hearing, and involves collaboration with the family, the police, the victim (if victim there is) and wider community services to come up with a rigorous care plan. It avoids criminalisation of the young person but has sufficient sanctions within it to ensure that the young person engages effectively and manages their risk alongside a robust support structure. More information is available here: <https://www.orangatamariki.govt.nz/youth-justice/family-group-conferences/> - the model is being used elsewhere (Australia and Germany) and is a nice diversion strategy with teeth to deliver what it's supposed to deliver.

If anyone would like more information about working in New Zealand as an adolescent forensic psychiatrist, drop me an **email** and I'll happily discuss further. I do miss good British beef burgers – for some reason it's hard to get good beef burgers here. So maybe bring your own beef, or your own cow.

We would love to hear from you! Email feedback, suggestions, and articles to waleed (waleedahmed@nhs.net)