Faculty of Child & Adolescent Psychiatry Executive Committee Newsletter

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In this issue
Virginia Davies

This edition comes to you fresh from the Faculty residential, so for any of you who either didn’t have the time, the money or fancied spending your time some other way, you can catch up on the news here. This is also the first edition of the newsletter to incorporate contributions from the wider readership. You’ll notice we now have a practitioner blog. I’d like to have a young CAMHS user’s blog as well, so if any of you have patients who are bloggers, please put them in contact with me via Stella Galea.

I’m delighted that this edition contains articles from a young person working with the Scottish executive, as well as a father and son who have been working with an IT
expert and a member of the Welsh executive to create a new app for patients with autism. We also hear from Rowan Munson, Youth Affairs Consultant, who feeds back about the Youth Select Committee enquiry into mental health, and Amy Gimson, the winner of this year’s medical student essay prize.

As well as the updates from the different jurisdictions, we have news from our new CAMHS lead for the Strategic Clinical Networks, Sandeep Ranote. Here you’ll find all you need to know about what money’s being released at what points over the next five years, and what it’s ring-fenced for. Get your sleeves rolled up and get involved in helping your local commissioners make successful bids!

A large part of this newsletter contains material from the other organisations with whom we work so closely. We hear from our colleagues at the NSPCC about the findings from their recent report *Always there when I need you: ChildLine Annual Review 2014/15*, as well as their collaboration with O2 to create a new resource for parents wishing to ensure their children are safe online. Our other colleagues at the Royal College of GPs then give us some sensible advice about how to structure our letters to GPs about patients with autism, and we finally hear about how a new e-learning resource was created by partnership working between our members and the Royal College of Paediatrics and Child Health.

Dan Hayes then gives us an extremely useful walk through the new Code of Practice. It may look long but, as Dan points out, the full version weighs in at 1.84kg. As such, I think we should congratulate him on his précising powers.

Given the need for something a little lighter after that, we have another of our new additions, a limerick from Mark Nathan. This one is about the dangers of cannabis use. I hope its presence in our rag may prompt some of the rest of you to consider submitting poems, photographs or pictures you’d like to share.

Then it’s back to things numerical: we have great news about the CAMHS data set, as well as new requests from CAPSS. And since it seemed to me that predicting risk lay in the same territory as surveillance, it is here that we have Michael Fitzgerald’s thoughts about how one might go about predicting who will be a mass killer.

One section I’d like to add in future newsletters at this juncture is a letters and comments section, so do write in if you have something you’d like to share with the wider readership. This can be related to content, or simply something you’ve been musing on, or wish to disseminate more widely.
Finally, we have Ann York’s heartfelt obituary for Steve Kingsbury. I wanted to end with this piece; it seems to me to embody the qualities of love, appreciation and respect that are so vital not only in our relationships with colleagues, but also in the relationships we have with our patients and those with whom they live.

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The chair’s column

Peter Hindley

I am writing following a highly successful residential conference. I would like to say thank you to you all who came to Brighton. It was wonderful conference with a wide range of high quality plenaries, symposia and workshops. This was down to two groups of people led by two remarkable women: the conference planning group led by our academic secretary, Ann le Couteur, and the conference team led by Catherine Ayres. If you did not come this year please put 6 and 7 October 2016 in your diaries. We will be holding our first joint conference with the General Adult Faculty in Birmingham.

I have to move on to much sadder news. Many of you will have known Steve Kingsbury. Steve worked as a child and adolescent psychiatrist in Hertfordshire and was a national figure in child and adolescent mental health. He worked for many years on service transformation with Ann York and was a key figure in CYP-IAPT and had been honorary secretary to the faculty executive. Sadly Steve died prematurely in April of this year and I would like to ask you to join me in mourning Steve’s sad death and in recognising the key contribution that he made in his professional life to CAP and CAMHS.

At the conference we heard more about recent developments in CAMHS in Scotland from Elaine Lockhart, Deputy Chair of the Faculty in Scotland. We also heard more about the CAMHS transformation programme in England from Martin McShane, Medical Director for Long Term Conditions. Martin McShane gave a clear undertaking that the Department of Health and NHS-England would argue in the strongest possible terms for the promised £1.25bn in new monies in the upcoming comprehensive spending review. Both of their presentations will be available via the College conference centre shortly.

In this newsletter Alka Ahuja describes in more detail the review of CAMH services in Wales and the new funding which is being made available there.

Coming back to England, I’d like to say a few words about the role the college is playing in the CAMHS transformation process. Just to update you, CYP-IAPT has now officially been renamed CAMHS Transformation. I have been working closely with Professor Peter Fonagy on three forthcoming curriculum development groups: combined psychopharmacological and psychological treatments; 0-4s; autism and learning difficulties. In my view, consultant child and adolescent psychiatrists should be playing a major role in developing and delivering local transformation
plans over the next five years, so I am organising a **day-long seminar on CAMHS transformation on 19 January 2016**. If you are interested in coming, please get in touch with me.

I’m conscious that recruitment into ST posts and recruitment to consultant posts in some parts of the country has been difficult over the past year or so. The Faculty is working in two ways: firstly by working with a Health Education England to create a new pathway into child and adolescent psychiatry; secondly, by specifically targeting awareness of CAP in medical students, foundation trainees and core trainees. Helen Bruce, chair of CAPFECC will tell you more. Last year in Cardiff, I told you about the **Values Based CAMHS Commission**. Lots of people have asked me what I mean by values. What I mean is what’s important to you. But what is important to you as consultants is not always the same as what is important to children and young people and their families and carers, to referrers, to managers and to commissioners. I think that this tension of what is important to the key constituents of the CAMHS system is crucial to understanding how best to deliver optimum services. With the support of the Dinwoodie Trust, we have appointed a research fellow, Fran Whitaker, who will be carrying out research in two parts of the country to understand these tensions. In January we will begin asking for evidence of best practice in delivering, managing and commissioning CAMH services which recognise and work with this tension. Baroness Claire Tyler has kindly agreed to chair the commission and Fran and I are meeting with her next week to agree the make-up of the commission. I will give more details in the next newsletter.

I want to touch on a few more areas. 0-25 services are being commissioned in a number of areas of the country. A joint CAP/GAF faculty draft statement of best practice will be coming out for consultation shortly. The Faculty is also participating in the College response to Choosing Wisely, the Academy of Medical Royal Colleges initiative to identify wasteful clinical practice. Bernadka Dubicka has led for the Faculty and a survey will be coming out to the membership of the college shortly. Can I ask you all to respond. Finally, Liz Fellow-Smith and Nigel Hughes have been leading on Urgent and Emergency Care and S136 for the faculty. Many thanks to all of you who completed the Faculty survey last year. We are now in detailed discussions with DoH and NHS-England to improve both areas.

Within the executive, we have had a strong carer representative presence in Sarah Robinson for the past two years. This year she was joined by Michelle Long and next year they will be joined by young people representatives.

Finally, I have been discussing with Simon Wessely and the executive how we should respond to the refugee humanitarian crisis. I’m drafting a statement based on UNCRC which I hope will form the basis of the college response.
I'd like to thank all of my colleagues, past and present, on the Faculty executive for their hard work and support over the past year and Stella Galea, our brilliant Faculty secretary, without whom we would be lost.

I am retiring from clinical practice in November. I intend to complete my term of office and demit in July 2017. I'm now halfway through my term of office and I would very much appreciate your feedback on how I am fulfilling my duties. Please email me on phindley@rcpsych.ac.uk.

Finally, I would like to link back to the theme of this conference’s plenary address: resilience. Professor Angie Hart spoke powerfully about the authority and influence of child and adolescent psychiatrists in the wider CAMH system. It was very heartening to hear such strong words of encouragement from a non-psychiatrist. I appreciate that we are working under very difficult circumstances throughout the UK, but I do believe that we all have the capacity to make a difference to children and young people, at all levels of their lives. And as you heard at the session ‘Your College’, if any of you would like to partner up with any of the Faculty leads for particular areas within child and adolescent mental health practice, do please contact them via Stella. Have a look at the list in our contacts section on page 41

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Report from Wales

In the last newsletter I had mentioned Together for Children and Young People, the multi-agency, multi-professional programme aimed at improving the emotional and mental health services provided for children and young people (CYP) in Wales. The programme was launched at the end of February 2015 and is being led by the NHS in Wales with the support of Welsh Government. Previous reviews of specialist Child and Adolescent Mental Health Services (CAMHS) in Wales had identified that the service is under more pressure than ever before, and in spite of additional investment and staffing, there has been over 100% increase in referrals to CAMHS over the last four years. Professor Mark Drakeford, Minister for Health and Social Services, has invited Professor Dame Sue Bailey to offer advice to support service development for CAMHS in Wales, in line with the Minister’s Prudent Healthcare agenda.
‘Together for Children and Young People’ (T4CYP) will consider ways to reshape, remodel and refocus the emotional and mental health services provided for children and young people in Wales.

I along with some of the college members attended the ‘Check and Challenge’ event on 22 June 2015 that updated on the work of the programme and agreed the ‘Framework for Action’ in response to the issues raised at the launch event in February. The Programme Board identified 4 key priority work streams

1. Early Years and Resilience of Young People
2. Early Intervention and Support
3. Neurodevelopmental Issues and Co-morbid MH / LD
4. Specialist CAMHS Pathway

Subsequently there was an announcement of the £7.65m annual investment in CAMHS, by the Minister and the monies were split as follows:

1. £2m to develop neurodevelopmental services
2. £800,000 to improve access for children and young people in Local Primary Mental Health Support Services
3. £1.1m to improve psychological therapies provision in CAMHS
4. £800,000 for early intervention in psychosis for the 14 to 25 age group
5. £250,000 to improve access to CAMHS by Youth Offending Teams and in-reach to those in the secure estate
6. £2.7m to improve crisis intervention, particularly in A&E and those detained under section 136, and also support Together for Children and Young People.

The health boards have put forward their collaborative bids and are awaiting the outcomes. The Minister has been clear that the investment should, as a priority, achieve a reduction in the waiting lists for specialist CAMHS and the expectation is that by the end of October 2015 all urgent assessments referrals to CAMHS would be undertaken within 48 hours and by 1 April 2016 all routine assessments would be undertaken within 28 days.

These are exciting times for children and young people’s services in Wales; on one hand there are challenges relating to workforce and recruitment, but on the other hand opportunities of reshaping our children services and working collaboratively with partner agencies. I shall keep you posted on future developments!!

Preparations are in full swing for the Young People’s Debate on 4th December 2015 and Professor Mark Drakeford, Minister for Health and Social Services has agreed to
inaugurate the event. The topic planned for the debate is “This House Believes that Social Media is Anti-Social”

The next **Faculty meeting** is in October and Professor Ilana Crome is presenting on clinical challenges in young people with substance misuse and mental illness.

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**ABOUT ME a mobile app for autism**

Peter Harvey, Dave Harvey, Alka Ahuja, Jacinta Tan, Sabarna Mukhopadhyay

This article describes a co-production process involving parent, child and professional partners working together to modernise an existent paper tool used for information sharing and support for children and young people with autism.

The challenges identified in diagnostic assessment of autism have been acknowledged at an international, national and regional level (NICE 2011, Autism Strategic Action Plan for Wales, 2008). Clinical experiences and evidence from research reflected the lack of clarity and transparency in the diagnostic process for autism and difficulties in information sharing and communication with families and professionals.

The **ABOUT ME** autism passport (paper version) was developed with advice and support from professionals involved in the autism diagnostic assessment process, but was centrally driven by parents and young people dissatisfied with the diagnostic process. It clearly described and informed families about the diagnostic process and helped them in their journey through the assessment pathway. The passport enabled parents and children to access, “hold” and share information and thereby reduce stress and anxiety for families and children. It provided a low cost solution to
well-known information sharing issues, and reduced stress and anxiety for families and children. It put the child at the centre of clinical practice.

A professional and parental partnership has driven this initiative from inception and this has already led to changes in work practice. The passport has been piloted in the autism clinics at Aneurin Bevan University Health Board (ABUHB) for over a year. Outcomes suggest that its use has enhanced delivery of person-centred health interventions and supported transparency and accountability in clinical practice. The passport supports improved planning and management thereby reducing stress for everyone.

It was developed as a live interactive document which would continue evolving to meet the needs of children. Feedback from young people suggested the next stage of the passport should be available as a mobile app to keep abreast with technology and promote sustainability and be most acceptable to young people for whom such apps are their preferred means of communication and information management.

The mobile app will allow access and easy sharing of information with services, especially at times of emergency e.g. a visit to A&E, when it is more likely to be available than a paper version. It will reduce time in duplicating history / information taking sessions. Having accurate information will mean that more suitable provision can be more easily identified and provided, which in turn will reduce anxiety and stress for the child/young person and family/carers, and thereby the number of high cost crisis situations experienced. It will be easily accessible for updating information, less intrusive than a paper copy, and the information it contains can be easily backed up, should the mobile phone or tablet break down or be lost. The investment in mobile apps will also make the passport sustainable without recurring costs for printing and memory sticks. Having ABOUT ME in mobile form will make this tool accessible to a much wider audience, not only nationally but also across the world.

The team co-created specifications for the proposed mobile app with professionals, young people with autism and their families. The clinical team were successful in obtaining a small grant from the Techealth innovation fund (Swansea University) last year which enabled us to start working with Peter Harvey (a young person with high functioning autism who has a passion for computers and mobile technology) and his father Dave Harvey (a radiologist by background but now a radiological IT developer and managing director of Medical Connections a small, medical software company). These credentials put Peter Harvey and Dave Harvey in an ideal position to lead the development of a prototype mobile app for ABOUT ME. Further collaboration with technology provider Sabarna Mukhopadhyay, via success at the Health Technology Challenge, has enabled decisions on the most appropriate platform for development
of the app, with consideration of the design, layout and options for entry and back up of data.

Peter comments: “At first, when I was asked to do this project, I was worried that I would not be able to complete it as early attempts to use Java and android ran into troubles. After weeks of trial and error, I found that once you get into coding it is very easy to do some cool looking stuff (i.e. calling from within an app) and in some cases even easier than some of the more basic bits. This has greatly advanced my programming skills and I am now studying computing at Gower College Swansea, and I think this will help me for the future.

A younger version of me would have found this app great. This app is very streamlined, so you can easily find what you’re looking for. This was a fun experience”.

In addition to creating the ABOUT ME app, this professional and parental collaboration has proven to be a catalyst for further development; this framework could be used to work with children and adults with other lifelong conditions such as epilepsy, schizophrenia, or physical conditions such as diabetes or inflammatory bowel disease. It could be particularly helpful at times of transition or crisis.

Peter Harvey, a young person with high functioning autism, and Dr Dave Harvey, his father, Professor Alka S Ahuja, Aneurin Bevan University Health Board, Clinical Associate Professor Jacinta Tan, Swansea University, Dr Sabarna Mukhopadhyay, SymlConnect Ltd

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Report from Scotland

Anne McFadyen

We were delighted for the first time ever to welcome service user representatives to our RCPsychiS Child and Adolescent Faculty executive meeting last month. Ella and Jack made great contributions but admitted to being baffled by some of the jargon. We resolved to make a dictionary of acronyms to help both them and us understand what is going on! Ella has also written something for this newsletter and we hope this will inspire other contributors to take our editor’s call to us all to be ‘more engaging and more participative’ to heart.

By the time this goes to press the annual residential conference will be behind us. Elaine Lockhart, Vice Chair of our faculty in Scotland, has risen to Peter’s challenge to take part in the hot topics session. There will be time spent considering our different
systems and she will share some of what is going on in Scotland with the wider child and adolescent psychiatry community. In the light of responses to the College paper on devolved administrations, we will again take the opportunity to remind colleagues of our different health, care and legal systems. As a Scottish faculty, we have commented on even more papers coming out from the College ‘as if we are all one’ and making no mention of the latter.

One of the most exciting pieces of joint working across specialty Faculties recently has been the development of our Healthy Start Healthy Scotland campaign. Plans for the launch on 23rd September at the Scottish Parliament are well under way, as are those for the RCPsychiS academic meeting on 1st and 2nd October, when a morning will be devoted to Early Years. In November, we will be holding our Faculty Academic Meeting and AGM when our theme will be a legal one. Our new service user reps have offered to present at the AGM and we look forward to supporting them to engage with our members.

Recruitment of trainees was better this round for both core trainees and for specialist training in child and adolescent psychiatry. However, we are aware that we must continue to actively work to recruit trainees into our specialty; we still have a shortage of consultants across Scotland. In pursuit of our strategy to attract more trainees, we had a strong representation from the faculty at the SMT Careers Fair held on 12th Sept at the SECC in Glasgow. It was encouraging to meet so many young people, including school pupils, medical students and FY doctors, who were interested in choosing a career in psychiatry. An interesting experience for me, as the only times I have been at the SECC previously have been to attend concerts (rock not classical).

On that theme, it is worth mentioning Graham Bryce (retired child and adolescent consultant) who is gigging with his band on 19th September to raise money for a project in Malawi. Fundraising for CAMHS research will also get a boost at the Great Scottish Run when some of the wider CAMHS community will be running to raise money for a new charity ‘Understanding Children’ which has been set up by Professor Helen Minnis. It is really good to see a development like this, as funding for mental health research in children probably doesn’t yet have the same profile as other charities.

As chair of the Faculty in Scotland I would welcome feedback from members about issues affecting you and your services at anne.mcfadyen@nhs.net or via the College Office scottishadmin@rcpsych.ac.uk.

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This month I have taken up a new role as a volunteer on the Child and Adolescent Faculty Executive Committee for Scotland, representing service users. I am nineteen and come to this role after an extensive period of treatment for anxiety from the Scottish Borders CAMHS team; it was actually my psychiatrist who suggested I applied for the position. Having been in treatment during my first year at secondary school and then again during my final two years, I’ve experienced the service from both a younger and slightly older patient’s perspective, which I hope will allow me to contribute usefully in this role. In addition to having been a patient, I have worked around mental health awareness and the stigma of mental illness in schools, having initiated and run a whole school mental health awareness programme which is now an ongoing feature of the school. This enabled me to hear the views of young people of varying ages about mental health which, again, I hope will be helpful in my work with the executive. I’d love to continue working in this area should the opportunity arise.

My first meeting of the Executive last week was really interesting, allowing me an initial insight into the workings of the College. That said, some of the acronyms and medical jargon did get the better of me, but I’m sure in time I’ll get the hang of that! The Executive members were wonderfully welcoming and made it very easy to join them and voice my views.

Over the next year I shall continue to attend meetings of the Executive. In November I will be attending the AGM and giving a short presentation, as will Jack the other service user representative on the Executive. I’m very much looking forward to this.

One of the main things I’d like to see happening during my time on the Executive is the development of a way to hear the views of more young patients from across Scotland. Personally I only have experience of the Scottish Borders service, but I’d love to see a network of young people putting forward views and ideas which could then be reflected back to the Executive.

In September I am moving into Edinburgh to take up my place at Edinburgh University studying history. However, if there is anything I could assist with or be involved in Scotland-wide, please don’t hesitate to get in touch via the Scottish Faculty Office.

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Report from Northern Ireland

Richard Wilson

Child and adolescent mental health services in Northern Ireland have been in the throes of transformation during the past year. The local faculty members have been engaged very actively with HSCB initiatives for the commissioning of CAMHS Services. Briefly this has involved the introduction of a Stepped Care Approach to service delivery across the region, with a more rationally differentiated and clearer elaboration of core and specialist child and adolescent mental health services. This has come in the wake of a thoroughgoing review of acute child and adolescent mental health services, a key aim of which is to engage and strengthen clinical leadership in the commissioning process and indeed at every level of service development.

As newly elected Chair of the Northern Ireland RCPsych Faculty, I am honoured to be chosen to help build on the excellent groundwork of Dr Heather Hanna and Dr Lisheen Cassidy and our colleagues. By forging sound relationships with the commissioners and partner agencies, the faculty is now in a strong position to influence the process of change.

At present the Northern Ireland cohort of CAMHS consultants numbers around 36 WTE, a dynamic group blessed with youth, energy and visionary talent. I intend to promote the faculty as a wellspring of support for consultants and as a source of expertise to guide, shape and refine the discipline of child and adolescent psychiatry in Northern Ireland, across the full spectrum of training, engagement with the public, and professional and clinical systems development.

Over the past year the faculty members have engaged with many thorny issues, not least the drafting of the new Mental Health Capacity legislation in Northern Ireland. We have been proactive in advocating for the importance to young people of having appropriate safeguarding of their rights, with regard to consent and treatment dilemmas.

Addictions and substance use have been on the rise in Northern Ireland over the past two decades, with painful consequences for young people and their families (including a rise in substance related deaths). The faculty in partnership with the Ulster Paediatric Society held a very successful Joint Academic Meeting Addictions Affecting Children and Young People in June 2015. Local CAMHS consultants Drs
Latimer and Gbolo-Teye, along with keynote speaker Dr Libby Ashurst, contributed to a rich learning event.

Original research in the CAMHS field is thriving in Northern Ireland. The STEP program, led by Professor Ciaran Mullholland, aims to evaluate the efficacy of a tailored cognitive behavioural intervention for young people presenting with early signs or risk indicators for psychotic illness. Another major project on Improving Mental Health Pathways and Care for Adolescents in Transition (IMPACT) continues across the region. This study poses the question ‘What is the best way to organise mental health services for young people in Northern Ireland, as they make the transition from CAMHS to Adult Mental Health Services?’ Led by Professor Gerry Leavy (University of Ulster), the study involves mapping of current transition practice across the province; longitudinal interviews with patients and families, and a multidisciplinary focus group and youth consultation panel are also planned. Faculty members Dr Mark Rodgers and Dr Claire Kelly are involved in this important venture. RC Psych Northern Ireland has supported trainees to develop solid research skills, which bodes well for the future.

At this point in time I would say that Northern Ireland is a vibrant and progressive place to practise child and adolescent psychiatry, and I am confident of seeing further positive developments during my tenure as faculty chair.

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Update from the NHSE CAMHS Strategic Clinical Networks
Sandeep Ranote

CAMHS has been referred to as a ‘Cinderella service’ due to its chronic under-resourcing and lack of identity as a separate service. Child and adolescent mental health services sometimes sit within children's trusts, sometimes within mental health trusts and sometimes within community trusts, but they never quite fit and almost always fall to the bottom of the pile. I strongly believe that as the first CAMHS lead for the Strategic Clinical Networks (SCN) in this country, the SCNs will be the vehicle that finally allows CAMHS to be seen and heard!

The Strategic Clinical Network CAMHS journey began in 2014 and 12 months on, we have established the first SCN CAMHS Advisory Group, sitting formally within the
NHS England SCN structures. We have built strong multi professional clinical representation from across the health and care economy. It is this collective leadership, with their 10 agreed values and standards, and the strengthening of relationships that is vital to improving provision and access to good quality, evidence-based child and adolescent mental health services that can listen and respond to young people and carers.

Following the ministerial taskforce, the SCN in Greater Manchester has taken the national lead for CAMHS and hosted the inaugural national CAMHS SCN event in London last March. We have also launched the country's virtual SCN CAMHS coalition, designed to be a 'critical friend' to local health economies as they deliver the taskforce recommendations and support CAMHS transformational plans. In May of this year, the team delivered the first dedicated CAMHS CCG training event, and have plans to support a national commissioning training programme for CAMHS in the future. As national lead for CAMHS, the Greater Manchester CAMHS network will play a pivotal clinical strategic role in Devolution Manchester and are hosting their second national SCN event in London this December with ministerial support from Alistair Burt (care minister).

We are delighted to have recently forged formal links with the Child and Adolescent Faculty Executive and look forward to working together in this exciting arena.

Some useful facts about SCNs, what they do, and the monies and spending they are seeking to influence across the country

- 12 strategic clinical networks (SCNs) across England
- Additional investment for CAMHS of £250m per year for 5 years ( £1.25bn in total )
- £142m confirmed for 2015/16, but £1.25bn will be over the 5 year period
- £133m on improving children and young people’s mental health, in addition to current local CAMHS budgets ( £75m for CCGs to enhance existing CAMHS and £58m for continued CYP IAPT roll out, in patient services, on line support, LD and youth justice )
- Separate from the above, £30m additional monies for 0-18 yrs young people's community eating disorder services recurrently for 5 years (£150m in total)
- Also additional, £9m for Health Education England for workforce development and training
• Also additional, £15m for perinatal mental health recurrently for 5 years (£75m in total)

• Transformational plans for CAMHS to be submitted by each CCG by 16 October 2015 - see guidance

• Successful schools pilot bids for non-recurrent funds announced (22 successful sites)

• Liaison funding across all ages ring-fenced; it is important for under 18s services to be involved in the planning of how these monies are used

• NHS England central CAMHS team developing

• National CAMHS commissioning training programme being considered

• SCNs are strengthening links with the Royal Colleges, third sector, education, social care and public health

• SCN are actively involved with Devolution Manchester, clinical lead member of CAMHS dedicated board

• CAMHS SCN lead will support delivery of RCPsych CAMHS transformational plans, development and delivery for psychiatrists training day being run by the Child and Adolescent Faculty on 16 January 2016

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Report from CAPFECC

Helen Bruce

It has been a busy year for the CAPFECC team with some exciting developments on the training front. We are pleased that the recommendation for six months training in Developmental Psychiatry to be compulsory in core training has been approved by the College and is currently with the GMC for their approval. This will mean that core trainees will have six months experience in either CAMHS or Intellectual Disability with sessions in the other prior to completion of core training.

In terms of new developments, we are working with Health Education England looking at the possibility of developing an additional route into training in child psychiatry. The traditional route of three years of core training and three years of
higher training will remain, but we are exploring the option of an additional route of entry at core training level to include a common core year with paediatrics.

CAPFECC is working in line with the College working party and the other FECCs to develop credentials. The GMC are currently consulting on credentials and we will have more information following the results of the consultation.

In line with the Shape of Training principles, CAPFECC is also looking at dual curricula with general adult psychiatry and psychotherapy. These dual trainings are likely to be two years in each specialty, with a common year to make up a five year training programme.

Recruitment remains a major concern following falling recruitment figures for the last few rounds. We see this as a priority area for the next year.

The medical student essay prize this year attracted a high standard of entries on the topic of "In these times of widening gaps in society between richer and poorer communities, how can deprivation and poverty affect child mental health?" The winner was Amy Gimson from Southampton, and we include her essay as an appendix to this newsletter.

If trainees, trainers or training programme directors wish to contact me to discuss any training issue, my email is helen.bruce@elft.nhs.uk

Dr Helen Bruce
Chair CAPFECC
helen.bruce@elft.nhs.uk

Trainees report: calling all wannabe trainee reps

Sylvia Baker

As next month approaches, it is time for me to hand over my responsibilities as the National Child and Adolescent Psychiatry Trainee Representative. I have thoroughly enjoyed my year as trainee representative, and have had the honour of organising, with the able assistance of Dr Matthew Fernando, the Psychiatric Trainees Committee representative, this year’s 14th Annual Trainee Child and Adolescent Psychiatry Conference. This will be held on Friday 9th October 2015 at Friends House, Euston, London and registration will be open this week (email cap.sprs@gmail.com for registration information).

As well as this, the role has afforded me a lot of interesting and useful experiences. I have attended the Faculty executive meetings and CAPFECC meetings, liaising with
many child and adolescent psychiatrists and putting forward trainees’ perspectives on child and adolescent psychiatry issues. I was involved in reading and marking essays from very bright medical students for the CAPFECC medical student essay prize, and also gave my opinions at the selection committee for posters and oral presentations for this year’s faculty residential conference. It has been an absolute pleasure being involved in these meetings and processes. I am sure the next National Trainee Representative will also enjoy the experience.

If any trainees are interested in taking up this role, I would thoroughly recommend it. I urge you to write a small description of yourself and reasons why you would be suitable for the role and send it to me on cap.sprs@gmail.com. Your nomination will be read out to child and adolescent psychiatry trainees at the National Annual Child and Adolescent Psychiatry Trainee Conference business meeting where an election will be held. It is usual that two trainee representatives will be elected. The next National Trainee Representatives will be announced on Friday 9th October 2015.

Good luck!

Dr Sylvia Baker ST6
National Trainee Representative for Child and Adolescent Psychiatry
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**CAMHS blog #1: the multidisciplinary team**

Dr Bloster

‘WINNIE: Win! *(Pause.) Oh this *is* a happy day, this will have been another happy day! *(Pause.) After all. *(Pause.) So Far.’

*Happy Days* Samuel Beckett, 1961

We are assembled at a corporate building somewhere in the metropolis. We are in the basement and there are no windows. The walls are a dirty white colour and the chairs are bright blue and seemingly indestructible. The carpet is nylon cord of a pepper and salt colour and the lights are fluorescent and very bright. Colleagues are divided into their teams and sitting at school tables. Our manager is giving a talk about the ‘future direction’ of CAMHS.

I am sitting with my team, who are mostly ‘Old CAMHS’. We are listening to the pep talk with a world-weary resignation. If our team had a uniform, it would be olive green, with chunky necklaces and Clark’s Nature-trekkers. This stereotype might be considered too urban for many of my colleagues, who out in the rest of the country may be on their own with a prescription pad. It does conjure something of the
origins of CAMHS - the melding of the child guidance clinics with their ‘nice ladies’, and the post 1948 interest in having medical practitioners available to these clinics to treat children with mental health problems. Men and women trained in psychotherapy and often having been psychoanalysed themselves were encouraged to put the communication needs of the child first. Psychotherapists are seldom found in CAMHS today. For my sophisticated and experienced colleagues, the times have changed radically. Time for case discussion and team reflection has dwindled and a ‘bums on seats’ and brief intervention culture reigns.

As a consultant, I am not against modernisation and providing the ‘right treatment for the right patient at the right time’, but my long apprenticeship in CAMHS and before that in the CFCS (Child and Family Consultation Service) has taught me that team function and wellbeing are important. How we work together in a considerate way is vital for how we work with our patients and their families. A functioning multidisciplinary team is containing for patients, but to provide this, we need time for us. Have we done away with the structures that united us as a team?

I consider all these things as the Powerpoint whirrs and the groovy younger members of the team scroll through Facebook. As a team leader I face considerable anger and resentment about working conditions, caseloads and patient and management expectations. I could intervene and change the way we all work for the better, redesigning the team timetable and putting in more space for reflection and joint working. What is stopping me?

I glance towards the plate of Bourbons, and remember an old friend and colleague. Before her retirement I used to go to her house, where we would work on research projects and service planning together in our own time. Her home was a glorious intellectual’s den - many a mouse perching on a forgotten plate of cheese and biscuits, with a very dusty vacuum cleaner propped up in the corner. Brilliant and wonderful, she had always appeared to fly into the room in a whirl of energy and files. After she retired and set about reorganising her life, I realised that she had simply been too busy to sort through the piles of old papers and mend the furniture. All her energy had gone into her work and her passion for child psychiatry.

Similarly, in CAMHS there are important things and unimportant things. At the moment we spend too much time assessing ourselves and not enough time on working and thinking with our teams about complex and traumatic cases. There may not always be solutions, treatments or good outcomes for all our patients, but at least at some stage they will reflect upon the fact that a group of thoughtful, kind and intelligent people were involved in taking time to think with them about their lives. Drifting back…..our manager is talking about how to divert patients from CAMHS, given that we have had 30% cuts to our service. We should only be seeing Tier 3 CAMHS cases, she says, and there is a weary wriggling of toes in the audience.
Feedback from the Youth Select Committee Inquiry Into Mental Health

Rowan Munson

Last year, 876,000 young people from across the United Kingdom engaged in a referendum identifying their main topics of concern. These were then passed on to the Youth Parliament in the House of Commons, and, following extensive debate, mental health was chosen as the topic most worthy of inquiry by the annual House of Commons Youth Select Committee for 2015.

The Youth Select Committee is comprised of eleven members aged 13-18, and I am privileged to be included among their number. We are supported by House of Commons Clerks to undertake the analysis of written and oral evidence, replicating the process of UK Parliamentary Select Committees.

The Committee focussed on three key themes and aspects of mental health; “Awareness”, “Education”, and “Services” for young people (under 25).

Professor Peter Fonagy, Clinical Director for Mental Health at NHS England, gave evidence and underlined the importance of improving this area of services. "Do not lose sight of the tremendous opportunity that improving the mental health of children and young people represents for all of us - not just those of us working in this field, but everyone around us, and not just now, but in the future. We have a lever to improve everyone's wellbeing through improving young people's wellbeing."

We posed a wide range of questions, focussed around Awareness, Education and Services, and invited written evidence to be submitted. We received 148 pieces of written evidence, which gave us an amazing base for our two oral evidence sessions.

The full terms of reference are available at http://tinyurl.com/YouthSelectMentalHealth
During the oral evidence sessions, we questioned and cross-examined a wide range of witnesses, including government ministers, young people, teachers and mental health professionals.

The evidence gathered allowed us to identify key themes and areas, with recommendations and conclusions for the government, who will be invited to formally respond.

Key areas highlighted by a range of witnesses included; the age of starting education – John Daziel, a deputy head teacher suggested “Let’s start teaching [mental health] in Year 1 and call it “What makes you happy?”; service integration and transition – Barbara Rayment, from Youth Access advocated the “Thrive” model, in place of the tiers, suggesting “They almost set organisations up against each other, and create barriers for young people going through”; parity of esteem and treating mental alongside physical health was also widely recommended amongst witnesses.

Ministers also took the opportunity to identify where the Youth Select Committee could contribute to government policy. Minister Alistair Burt MP, Minister for Community and Social Care, suggested "How we keep children and young people safe on the internet, ideas for future digital apps, and how we can improve children and young people’s participation in policy making and planning for implementation". Sam Gymiah MP, Minister for Childcare and Education, said "What can we do on a big scale to get peer-to-peer support working, as part of our response in dealing with young people’s mental health issues?"

Both ministers were committed to working together to establish better mental health in young people. Minister Burt commented “I am looking forward to the forthcoming report and would like to continue to work with the members, so we can ensure that their views are incorporated into our work.”

The report will be publicly available following its official launch next month. You are invited to attend the report launch. Tickets need to be booked in advance and are on a first-come, first-served basis, bookable shortly through http://www.byc.org.uk/

If you have any other questions or queries about the process or report, please contact Anna Sterckx at the British Youth Council anna.sterckx@byc.org.uk

Rowan Munson
Youth Affairs Consultant and Campaigner
c/o anna.sterckx@byc.org.uk
**News from our colleagues at the NSPCC**

Chris Cloke

**Always there when I need you: ChildLine Annual Review 2014/15**

On Thursday 10 September, the NSPCC published the Annual Review of ChildLine’s helpline activity covering the period 2014/15. The review reports that in 2014/15 there were nearly 290,000 ChildLine counselling sessions with children and young people about issues affecting them.

The top ten reasons about which children and young people contacted ChildLine were

1. Family Relationships
2. Low self esteem/unhappiness
3. Abuse
4. Bullying/online bullying
5. Self harm
6. Suicidal
7. Friendship Issues
8. Sex/relationships/puberty/sexual health
9. School/education problems
10. Mental health/depressive disorders

The review provides an analysis of the numbers of children and young people counselled by ChildLine, their characteristics, and trends over recent years.

Abuse remains a priority issue that children and young people contact ChildLine about. Last year over 26,000 children and young people contacted ChildLine with concerns about sexual, physical or emotional abuse or neglect.

**Always there when I need you** focuses on mental health and wellbeing concerns. As can be seen from the listing above, **four of the top ten reasons for contacting ChildLine relate to mental health.**
ChildLine found that, worryingly, many young people felt they received little help and were unable to get the vital help they needed.

You can read the ChildLine annual review, *Always there when I need you*, on the NSPCC website, [www.nspcc.org.uk](http://www.nspcc.org.uk).

**Tackling on-line safety: partnership announced between 02 and NSPCC**

This recently partnership between 02 and the NSPCC seeks to ensure that parents have access to practical advice and support to help keep their children safe online. One-on-one free expert technical advice is available to parents via a dedicated new helpline (0808 800 5002), as well as interactive workshops delivered in workplaces and schools.

Full details of the partnership are available on the NSPCC website ([www.nspcc.org.uk](http://www.nspcc.org.uk)) and on [www.02.co.uk/nspcc](http://www.02.co.uk/nspcc).

**Can you help promote these initiatives?**

The NSPCC would welcome your feedback about and support for these initiatives. If you have any comments, please do not hesitate to contact Chris Cloke

Christopher Cloke  
Head of Professional Reputation and Local Campaigns NSPCC  
Chris.CLOKE@NSPCC.org.uk

**Advice from the Royal College of GPs about letters to GPs regarding patients with autistic spectrum disorder**

Carole Buckley

GPs may have to look at more than 50 documents a day. As such, they rarely have the time to read lengthy diagnostic letters. Important information is lost unless it is set out in a succinct covering letter which forms the first front page. The information, which includes diagnoses and action points, is helped by being in a standard format.

The information should be clear and precise, particularly as this is likely to be the only complete clinical record in the UK.
- Put the diagnosis in bold writing
- Add additional diagnoses (e.g. anxiety, depression, intellectual disability) at the same time
- Suggest the Read code to be used. e.g.

<table>
<thead>
<tr>
<th>ICD code</th>
<th>Read code</th>
</tr>
</thead>
<tbody>
<tr>
<td>F84.0</td>
<td>Eu840</td>
</tr>
<tr>
<td>F84.1</td>
<td>Eu841</td>
</tr>
<tr>
<td>F84.5</td>
<td>Eu845</td>
</tr>
<tr>
<td>(DSM 5)</td>
<td>Eu84z-1</td>
</tr>
<tr>
<td>F84.9</td>
<td>Eu84z</td>
</tr>
<tr>
<td>1J9</td>
<td></td>
</tr>
</tbody>
</table>

- If there is any doubt about the diagnosis or if further evaluation is needed make this very clear – and use “suspected autism” as the code.
- It is difficult to get a code off the system once erroneously entered
- Comment on the capacity to consent to treatment on the front page and highlight any issues.
- Set out medication changes on the front page and emphasise that these are changes (do not simply list drugs as the GP may miss the changes).
- Make any actions you want the GP to take clear. Put them in bold and on the front page. Do not lose them in the middle of a paragraph.
- The full formulation is fine to send and can be stored on the computer system for future use if needed but it is unlikely to be read

Even if the main letter is addressed to the patient and written to them, ensure that the GP’s copy includes this summary top sheet.

**An example of a front page:**

Dear Dr:

Re: Mr. X  (d.o.b).

Address

NHS no

**Diagnoses:**  Childhood autism (ICD10 F84.0 Read code: Eu840 )
Social phobic anxiety disorder (ICD10 F40.1)

Current Medication: none

Medication change recommended: Start sertraline at 25mg increasing at 25mg monthly to max 100mg (for anxiety).

Capacity to consent to treatment:

He has problems thinking about the future hypothetically so he may prove not to have capacity. This can be improved by setting out the options in diagrammatic form.

He is considered to have capacity to consent to medication changes.

Immediate Risks of concern: His impending divorce may increase stress and risk.

We recommend the following actions:

A) We are arranging further assessment of his sensory issues.
B) **We have asked Mr. X to meet you to discuss starting sertraline for his anxiety.**
C) We have advised Mr. X to seek a care needs assessment
D) We are offering him and his spouse post diagnostic education group.
E) We are drafting a hospital passport with him and will ask him to discuss it at surgery. **Please note the reasonable adjustment in the hospital passport and draw attention to it mention when referring to other services.**

Thank you for referral – I attach the full diagnostic letter that has been sent to Mr X. The items above are a summary of our findings and recommendations.

Yours sincerely

Carole Buckley
RCGP champion for autistic spectrum disorders

Contact Dr Tom Berney for more information t.p.berney@newcastle.ac.uk
The genesis of Disability Matters, a new e-learning resource

Mark Lovell

Disability Matters is a Department of Health funded series of e-learning sessions about different disabilities and related issues within children and adolescents. It involved a collaboration of many like-minded agencies coordinated by Disability Matters (Royal College of Paediatrics and Child Health).

For me, it started with an invitation to contribute to Disability Matters from Pru Allington-Smith, a fellow Child and Adolescent Intellectual Disability Psychiatry Network (CAIDPN) committee member. A group of child and adolescent intellectual disability psychiatrists agreed to contribute and we were allocated a variety of e-learning sessions to create. We were given a session brief and a program called Huddle to engage with. This allowed parents, co-authors and children with a range of disabilities to comment on the e-learning session content as it was developed. Once the content was agreed to be meeting the session brief, we left the Huddle system and worked directly with an instructional designer (Alice Denham) who had the task of turning our content into a useable, interactive e-learning format that was both informative as well as visually appealing.

The sessions were produced over a 15 month period by children with disabilities, young people, parent carers and other experts. With an inclusive target audience of ‘everyone who may work with, volunteers with, care for, commission or deliver services for disabled children, young people and their families’. The aim was to improve outcomes that mattered to the contributors through the production of 20-40 minute long e-learning sessions.

Disability Matters launched on the 3rd February 2015 with 27 e-learning sessions and over the subsequent months, 58 sessions in total were produced. These were split into 6 domains: understanding disability (8 sessions), person to person (13 sessions), family and society (13 sessions), decision making and growing up (9 sessions), behaviour and emotions (5 sessions) and health and wellbeing (10 sessions).
I had involvement on two of the sessions which were linked. These were: ‘The different meanings of behaviours’ and ‘Responding positively when behaviours are seen as challenging’. I collaborated with a paediatrician (Max Davie) who is also involved with MindEd, a highly specialist speech and language therapist in positive behavioural support (Steph Carr), a clinical nurse specialist in positive behavioural support (Steph Fenwick) and another child and adolescent intellectual disability psychiatrist (Taiwo Adewumi).

Reflecting upon the experience of being an author, it certainly was worth it in the end. I’m proud of what we produced and really value the opportunity that I was given. As with many projects, I certainly underestimated the time commitment and at times the set deadlines and targets within the project were difficult to meet alongside my fulltime consultant psychiatric role and other professional responsibilities. Being constantly fed back to by others who may or may not have shared the same agenda as myself or even at times a shared medical language was a challenge, which also brought home the difficulties in writing for a wide range of readers simultaneously. Style, language use and content were all considered by the wider development team, often requiring multiple re-workings of the session. This however, was also a major positive when it came to producing the end product. The feedback was candid and at times difficult to respond to, but made me reflect upon my use of language and how to get my message across in a more accessible way. It forced me to decide what was important to say and whether my own views were valid. It also highlighted key differences between how a psychiatrist and a child or parent might view the same issue, the range of potential treatments and use of words. The end product was certainly enhanced by the comments and suggestions of the wider session development team.

I really enjoyed working with an instructional designer and my co-authors and felt that the final sessions were worthwhile. I hope that they will serve to educate those that are unfamiliar with the disability fields and that they will have a long lasting reach. I learnt about the creation of e-learning sessions and I will certainly allow more time in my diary the next time I’m asked to contribute to a similar project.

The Disability Matters sessions are available at www.disabilitymatters.org.uk and are worth a look for yourself, trainees, colleagues in both the multidisciplinary and multi-agency settings and also for parents and young people not just to inform and educate, but also to allow personal reflection on a variety of issues.

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The new Mental Health Act Code of Practice and its implications for those working with children and young people

Dan Hayes

The latest iteration of the Mental Health Act Code of Practice came into force on 1st April 2015. Despite the auspicious launch date, the new Code represented the outcome of a lengthy and considered piece of work by politicians, civil servants, clinicians, lawyers and a wide range of interested parties but, above all, service users and their carers, whose views were given a prominence not seen in previous versions of the Code.

The explicit aim was to provide a ‘stronger code, better care’. Whilst the increase in the size of the Codes, from 170 pages in 1990 to 462 pages in 2015, was met with inevitable grumbles about the juridification1 of mental health care, the new Code does endeavour to provide clinicians, and indeed service users, with a resource to negotiate the increasingly complex interplay between clinical practice and the law.

The Code provides statutory guidance for doctors and other mental health professionals on how to implement the primary legislation (Mental Health Act 1983), and its regular revisions have reflected the changing landscape of health care provision, the introduction of other legislation (e.g. Mental Capacity Act 1995, Human Rights Act 1998, Equalities Act 2010), important case law (e.g. ‘Cheshire West’) and the influence of more widely held perceptions about how mental health care should be delivered. The latest revision of the Code explicitly operationalised a shift in emphasis towards promoting individualised, collaborative care, and away from the use of inappropriate or ‘blanket’ restrictions, wherever possible. The impact of scandals such as Winterbourne View and Mid Staffordshire was a clear driver for such changes.

The chapter in the Code relating to ‘children and young people under the age of 18’ was one that was identified as being in need of significant revision and the 28 page Chapter 36 at the end of the 2008 Code has increased in size and prominence to become the 37 page Chapter 19.

Particular focus is given in this chapter to the interplay between the Mental Health Act, and other relevant legislation, such as the Children Act 1989 and 2004, the Mental Capacity Act and the Human Rights Act in relation to children (under 16) and young people (16 and 17). Key themes that emerge are whether children or young

1 “the proliferation of rules and legal formalities in previously unregulated sectors of society”
people are able to agree to treatment in their own right, by assessing their ability to competently or capacitously consent, and the appropriate mechanism for the provision of assessment and/or treatment if they are unwilling or unable to consent, including the circumstances in which it is appropriate, or not, for those with parental responsibility to consent on their behalf.

Chapter 19 also highlights specific provisions relating to the treatment of children and young people under the Act, which can differ from those relating to adults, and upon the duties incumbent upon services looking after children and young people subject to the Act, whether they are mental health services (e.g. duty to provide age appropriate accommodation) or other agencies, such as education or local authorities.

The ‘general considerations’ that open the chapter will come as no surprise to the CAMHS practitioner, but may be a helpful reminder to others of the necessity of a multi-agency approach to, and joint responsibility for, the care and welfare of children and young peoples, and the developmental process which provides the context for that decision making.

The Code is explicit that ‘the valid consent of a child or young person will be sufficient authority for their admission to hospital and/or treatment for mental disorder; additional consent by a person with parental responsibility will not be required’ (CoP 19:21) although notes that it is good practice to involve parents or carers in the decision making process.

This raises the obvious question of what constitutes ‘valid consent’. The law differentiates between under 16 year olds and 16 and 17 year olds with regard to admission and treatment decisions, and whilst the principle of valid consent underpinning the right to informal admission is applicable to all, how such consent is obtained, and deemed valid, differs according to the age of the child or young person.

The Mental Capacity Act applies to everyone aged 16 or over. There is a presumption of capacity, so young people must be assumed to be able to make a decision about admission and/or treatment, unless it is established that they lack capacity, by the mechanism of determining that they are unable to understand, retain, or use information pertinent to the decision, or are unable to communicate that decision. Section 131 of the Mental Health Act means that if a young person has capacity, they may consent, or refuse to consent, to a proposed informal admission. The views of someone with parental responsibility, either in terms of trying to prevent an admission that has been consented to, or wishing to consent on behalf of a refusing young person, whilst they may be clinically relevant, have no weight in the legal decision making process.
16 and 17 year olds who lack capacity to consent may possibly be admitted to hospital informally in accordance with the provisions of the Mental Capacity Act, but not if the admission amounts to a deprivation of liberty. Given the recent expansion of what constitutes a deprivation of liberty, as outlined in the Supreme Court’s Judgement in Cheshire West\(^2\), it is increasingly difficult to take a view that the conditions inherent in admission to hospital, if someone is unable to consent to them, do not amount to a deprivation of liberty, no matter how benign or therapeutic the intentions behind them. Although young people are subject to the Mental Capacity Act, Deprivation or Liberty safeguard (DoLS) are not engaged until 18 years of age, so practically speaking, the route for admission of a capacitous but not consenting, or a not capacitous 16 or 17 year old should be via the Mental Health Act, if the criteria for detention are met. For 16 and 17 year olds it is also important to appreciate that, whilst usually inextricably linked, decisions about admission and about treatment are different decisions that have to be addressed independently.

Under 16 year olds have the same right to validly consent to informal admission as young people and adults, but being out with the scope of the Mental Capacity Act, the determination of whether they can consent is via an assessment of (Gillick) competence. The 2008 Code gave little practical guidance on the assessment of competence, other than that derived from the original judgement\(^3\), of a need to determine whether the child had ‘sufficient understanding and intelligence to enable them to fully understand what is involved in a proposed intervention’ which would then allow them to consent to that intervention.

The 2015 Code is much more explicit in how competence should be assessed (CoP 19.34-37), and it is now difficult to distinguish the assessment of competence from that for capacity, in that the same 4 aspects of decision making and communication are required. This offers helpful clarity to practitioners, allowing a more focussed approach to the question of whether an individual can validly consent, or not, rather than implying capacity and competence are somehow conceptually different. However, although weight must be given to the views of the child, especially in the context of developing maturity and autonomy, it is important to remember there is no presumption of competence as there is of capacity. Having said that it is vital to not fall into the easy trap of deciding that children who agree with their doctors are competent, whereas those who do not, are not.

Decisions made by those with parental responsibility should not be used to over-rule the refusal of a competent child, or consent on their behalf. The Code is explicit that ‘it is not advisable’ (CoP 19.39) to seek to admit or treat a child who is competent

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\(^2\) P v Cheshire West and Chester Council and another and P and Q v Surrey County Council. 2014

\(^3\) Gillick v West Norfolk and Wisbech Area Health Authority 1986
but refusing using parental consent, noting that previous court rulings that such a practice was acceptable antedated the Human Rights Act, and that since then ‘court decisions concerning children and young people have given greater weight to their views’.

Why a child may lack competence, ignoring the complexities of actual clinical practice, can, somewhat artificially, be divided into 2 domains. There are those children who by virtue of mental disorder have lost the ability to competently consent, but who otherwise would have been deemed competent, for example a 15 year old with a florid psychotic illness. There are also those children who solely by virtue of age, would not be deemed competent, because at the age of 8 or 10 for example, they do not have the ‘sufficient understanding or intelligence’ required to consent, irrespective of the presence of mental disorder.

How we approach these 2 different groups, and who can authorise the admission and treatment they are unable to consent to themselves, is dependent upon factors relating to the child and what interventions are proposed, and central to this is an understanding of the role of those with parental responsibility, and of what they can, and what they cannot, consent to on behalf of their child.

The 2008 Code introduced the concept of the Zone of Parental Responsibility (ZPC) to describe the type of decisions that a parent could make on behalf of their child, and the circumstances under which such decisions could be made. In the 2015 Code, this term has been replaced by the Scope of Parental Responsibility, and provides greater clarity about how to determine whether a decision falls within the scope of parental responsibility. (CoP 19.38-19.42).

All such decisions have to be considered in relation to the specific circumstances of the case, and whether this is a decision that a parent ‘should reasonably be expected to make’, and whether there are any factors that ‘might undermine the validity of parental consent’. Despite an understandable desire from practitioners for a definitive list of what is within, and what is without, the scope of parental responsibility it is impossible to oblige. This reflects the inevitable, and developmentally appropriate, erosion of parental control over the matter of a decade or so, that sees parents having complete and absolute authority over all aspects of their child’s life in early childhood, to providing them with advice that they may disregard by the time they reach their middle teenage years. Consequently what may be unequivocally a decision that it is reasonable for the parent of a 10 year old to make, may be less clear cut when that child is 13, and clearly not a decision they can make when that child is 15.

Factors that would sway the decision making away from being within the scope of parental responsibility would be the type and invasiveness of the proposed
intervention, and any resistance to it, the increasing age, maturity and understanding of the child, and inconsistency with any known wishes, or previously expressed views of the child, especially if they were made known at a time when the child had competence. In the hypothetic scenario briefly mentioned above, of a previously competent 15 year old with a psychosis who had lost the ability to validly consent to admission and/or treatment by virtue of a their illness, it would almost certainly be inappropriate to rely on parental consent to authorise their care, especially if it involved any coercive or restrictive practices, or if it contrasted with previously held views, such as treatment with a medication the child had previously expressed an aversion to.

Equally, even if a parent did consent, it may not be appropriate to rely on that consent if there were concerns about its validity, for example where the parent lacked capacity themselves, could not prioritise what was in the child’s best interests or in the context of significant discord between parents. Under such circumstances it would be appropriate to provide admission and/or treatment under the Mental Health Act, if the criteria were met.

Notwithstanding previous comments about decisions needing to be taken on a case by case basis to determine whether parents could consent to a specific intervention, one absolute criterion seemed to be well established by case law, which was that parents could not consent to something that amounted to a deprivation of liberty for their child.4

Crucially a deprivation of liberty engages an individual’s Article 5 rights (the right to liberty)5, and it is ‘It is unlawful for a public authority to act in a way which is incompatible with a Convention Right.’6, and these rights apply to people of all ages.

The ‘Cheshire West’ judgement has given us a mechanism by which to determine whether a deprivation of liberty is taking placing; the so called ‘acid test’. (‘Is the person subject to continuous supervision and control?’ and ‘Is the person free to leave?’ in a situation where the person lacks capacity to consent to these arrangements). This represents a clear expansion of what constitutes a deprivation of liberty, and means that many people, and not only in mental health settings, who were not previously considered to be deprived of their liberty are now in that position. One of the cases considered in the ruling, Mig, was of particular relevance, ‘She was living in an ordinary family home, and also going out to attend an educational unit, and enjoying good family contact.’ Whilst surely all clinicians would

4 RK v BCC [2011]
5 European Convention on human rights
6 Human Rights Act 1998 6(1)
regard this as a good outcome she was still held to be deprived of her liberty, for
cogently argued reasons.

It is important to appreciate that there is nothing inherently wrong with depriving
someone of their liberty, and indeed it may well be clinically appropriate, or
essential to do so, but practitioners must be aware that they are doing it, and
constantly scrutinise situations that may amount to a deprivation of liberty to
determine if they do, and ensure that there is an appropriate mechanism in place to
authorise a deprivation of liberty if it is taking place.

The 2015 Code notes the uncertainty post Cheshire West about whether someone
with parental responsibility could consent to something that would amount to a
depprivation of liberty (CoP 19.48), given the Supreme Court did not expressly clarify
the issue. Recent case law\(^7\) has ruled that a deprivation of liberty can fall within the
ambit of parental responsibility, but the decision was not uncontroversial, and
practitioners are strongly advised not to rely on parental authority to authorise a
depprivation of liberty unquestioningly and follow the advice of the Code, to ‘seek
their own legal advice in respect of cases before them’, and to ‘consider and apply
developments in case law following Cheshire West’.

It is likely that case law will emerge to clarify whether, and in what circumstances,
parental authority could authorise a deprivation of liberty. It is most probable that
this will be relation to younger children where the care regime and restrictions
placed upon the child in a care setting accord with the degree of parental oversight
that might be expected for a child of that age, but are held to amount to a
depprivation of liberty. As children get older the courts have consistently given
greater weight to their views and autonomy, so it seems highly unlikely that parental
consent will give any viable mechanism for authorising a deprivation of liberty for
the overwhelming majority of young people who require inpatient psychiatric care,
given they are teenagers with the precocious onset of severe mental illness, and
practitioners are urged to continue to use the Mental Health Act as the most
appropriate mechanism for authorising their deprivation of liberty, if it is necessary
to do so, and criteria are met.

As if the complexities around issues of capacity, competence and consent outlined
already were not sufficiently difficult to negotiate, the Mental Health Act and Mental
Capacity Act Codes of Practice point out that not all young people who are unable to
make a decision will lack capacity within the meaning of the Mental Capacity Act.
The concept of the ‘overwhelmed’ young person who has capacity but cannot make
a decision (CoP 19.31-19.33) is helpfully expanded upon in the new edition of the

\(^7\) Re D (A Child: Deprivation of liberty) [2015]
Code, with significantly greater emphasis given on the need to provide the support and information necessary to enable the young person to make a decision.

The 2015 Code expands upon the duty to provide age appropriate accommodation for young people admitted to hospital, whether they are detained under the Act or not. Whilst it notes that admissions of young people to adult wards are not prohibited, it is Government policy that under 16 year olds should not be admitted to adult wards. For 16 and 17 year olds admission to an adult ward would be permissible in 2 circumstances. The ‘emergency situation’, which should be ‘rare and unusual’, is one in which where the risks of not admitting to an adult ward outweigh the risks of doing so, and which should be rectified by timely transfer to age appropriate accommodation. The ‘atypical case’ is one where the young person’s needs would be better met by an adult service, for example, admitting a post-natally depressed 17 year old to a Mother and Baby Unit, rather than separating her from her child to admit her to age appropriate accommodation (CoP 19.90-19.104).

The 2015 Code is also clear that in relation to identifying a place of safety for a young person detained under S136 ‘the healthcare setting identified by local policies as the place of safety should be used, and the fact that this is attached to an adult ward should not preclude its use for this purpose’ (CoP 19.105). The responsibility of mental health services is to ensure that a timely resolution of the S136 is achieved, not to delay the process by failing to determine where a young person should be assessed for that purpose.

Given the multi-agency nature of that the care of children and young people with a mental disorder usually require, the 2015 Code expands upon the duties of other agencies, such as education (CoP 19.116-19.118) and local authorities (CoP 19.121-19.126), and also helpfully makes recommendations about how transition from CAMHS should be undertaken (CoP 19.119-120).

Hopefully this article will give colleagues a brief overview of the major themes and revisions in the 2015 Code of Practice, but obviously does not provide a substitute for familiarity with the Code itself, which ‘professionals should have detailed knowledge of’ (CoP II).

The Code can be downloaded as a PDF (https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983), which may be preferable as a means of access, as I am reliably informed the hard copy weighs in at 1.84kg!

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**CAMHS limerick #1: on the dangers of cannabis use**

A cannabis smoker from Guam
Insisted dope did him no harm.
Yet when he ran out,
He tended to shout
A great deal and could not keep calm

Dr Mark Nathan
Consultant Child and Adolescent Psychiatrist, Enfield CAMHS
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**Update about the Mental Health Service Data Set (MHSDS) aka CAMHS data set: we have lift off**

Margaret Oates

The development of a CAMHS data standard has been a long and sometimes frustrating journey. The good news is that the data standard has now been approved by the Standardised Committee for Care Information (SCCI). This mandates services to start collecting data in line with the requirement from January 2016 and submit data to the HSCIC from February. The Information Standard notice, all supporting documentation including the technical specification and related guidance can be found at [http://www.hscic.gov.uk/isce/publication/SCCI0011](http://www.hscic.gov.uk/isce/publication/SCCI0011)

Margaret Oates
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**Update from the Child and Adolescent Psychiatry Surveillance System (CAPSS)**

Adi Sharma, Alan Quirk and Tamsin Ford

We hope to have met you at the drinks reception that CAPSS hosted at the Annual Residential RCPsych Child and Adolescent Faculty Conference at Brighton. This is an exciting time for CAPSS with a study of the transition from child to adult services (Catch Us) starting shortly and several others in the pipeline.

We can also now offer Royal College CPD certificates for those who return cards and questionnaires to document this research related activity.
We are glad to welcome our new trainee representative, Dr Jaya Gupta, and would be glad to welcome more new blood (trainee or consultant). The commitment is four meetings per year, all in London but it is possible to join via phone or video link for up to two of them and involvement in reviewing one study per year. Meetings are held at the Royal College of Psychiatrists, travel expenses are reimbursed and lunch provided if you attend face to face. Anyone interested please email capss@rcpsych.ac.uk.

And finally, please do contact us as capss@rcpsych.ac.uk if you are a consultant and are not receiving a card or have moved jobs recently so we can keep our database up to date.

Adi Sharma, Alan Quirk and Tamsin Ford
On behalf CAPSS Executive Committee

capss@rcpsych.ac.uk

Mass Killers: three new books

Michael Fitzgerald

Can we identify a mass murderer (e.g. pilot, school shooter etc) in advance?
These are extremely rare events and by their nature are almost impossible to predict with any degree of accuracy. Nevertheless, as we try, we must also realise that many of the individual features I describe in the profiles of potential mass killers are not rare in the general population. It is the overall picture that is relevant.

In assessing risk, we must look at the individual’s

1. Medical history pattern: whether it deviates from the average medical history pattern of pilots, students, military personnel etc

2. Childhood history of being bullied, being a loner, being a very routine-bound person with special interests in death, perversions, dead animals, serial killers, mass killing, police work, military activities, horror movies, killing of animals, e.g. cats etc, showing callous and unemotional traits, moodiness and showing gross lack of empathy, problems reading other people's minds emotionally, being excessively controlling and dominating, problems with reciprocal social relationships, having sensory problems, noise, taste, touch, being significantly clumsily, being very unpopular in school but having special
talents with numbers, mathematics, technology, engineering, construction and logic.

Other features would include poor eye contact, problems reading non-verbal behaviour, problems sharing emotional thoughts, problems turn taking and being very poor at group games. Many or most readers will dismiss this profile as nonsensical. The only answered to them is to ask them to produce a better alternative approach to the problem. Clearly we have to be extremely careful in labelling people inappropriately. If one is totally anti-labelling or identifying potential mass killers, then one has to accept the activity of mass killers.

If one hears of a person who is in an average job and who has never performed above the average or indeed less than the average level and they state they will one day be famous and that “everyone will know my name” and they have the profile outlined above, then airline management or schools managers or army commanders should ask some questions and explore the background and motive of this person a little more. If, in addition to the profile already described, a person is depressed, has recently experienced stress at his job, has had a personal relationship breakup or conflict with his employers, or problems with his work performance, and is in a position of major responsibility e.g. airline pilot, then they should be examined further, if they make unusual and bizarre statements which could be taken as a joke if one wasn't listening carefully.

Another scenario is a pupil (almost always male) with the profile described, who shows strange comments on his social media sites, has been bullied (or is being bullied in school), is depressed, ostracised, can’t relate to girls, is a loner, has had an academic crisis or access to guns at home or elsewhere and makes violent threats. These should be investigated by the health and safety officer in school (who should be responsible for gun attacks in school) in conjunction with the management of the school where a thorough investigation should take place. Readers should keep Adam Lanza, Harold Shipman and Timothy McVey in mind.

References:

2. ‘Young Violent and Dangerous to Know’, by Michael Fitzgerald, published by Novinka, New York 2013


Professor Michael Fitzgerald, Department of Psychiatry, Trinity College Dublin
c/o sgalea@rcpsych.ac.uk
Call for submissions from the EPA

24th European Congress of Psychiatry (EPA 2016)
12-15 March 2016, in Madrid, Spain
http://www.epa-congress.org/
Abstract Submission Deadline: 6 October 2015
Early Registration Deadline: 18 January 2016

The 24th European Congress of Psychiatry (EPA 2016), will take place in Madrid, Spain on 12-15 March 2016. Guided by the motto "Towards a Common Language in European Psychiatry", EPA 2016 will cover the newest psychiatric achievements: basic, clinical and translational research, and their application to evidence-based practice in diagnosis, treatment and education.

Submit your abstract for EPA 2016 and join us at Europe's leading platform devoted to facilitating a robust exchange of ideas, reflection and collaboration across all fields of psychiatry.

We need you.
Fancy being a regional rep?

Child and Adolescent Regional Representatives needed

There are a few vacancies for Child and Adolescent Regional Representatives currently available:

- Oxford Region, South Eastern Division
- KSS Region, South Eastern Division
- Eastern Division (Deputy RR)
- Central and North East London Region, London Division
- South West London Region, London Division
- Yorkshire Region, Northern & Yorkshire/North West Division (job share)

Regional Representatives assist the Regional Advisors by assessing new consultant and specialty doctor job descriptions so that the Regional Advisor can reply appropriately to Trusts. The majority of job descriptions need some alterations to be made to bring them into line with College aspirations and standards. In the smaller specialties there are relatively few new job descriptions, so the role is not arduous,
but nevertheless very important as it is the main way in which the College can influence Trusts to maintain high quality and training standards when they are planning new posts.

Becoming a Regional Representative is an ideal way for someone to become more involved in the work of the College without taking on a high level of time commitment.

Regional Specialty Representatives will:

- have a keen interest in maintaining standards of consultant and other career grade psychiatrists
- be full, current members of the College
- have held a substantive consultant post for at least three years
- be in good standing with the College for CPD
- be able to fulfil the requirements of the post
- have discussed the role with their employer and the employer is content to allow the time needed to carry out the role
- be up to date with their membership fees.

Anyone interested in taking up one of these posts should contact your local division office for further details - [http://www.rcpsych.ac.uk/workinpsychiatry/divisions.aspx](http://www.rcpsych.ac.uk/workinpsychiatry/divisions.aspx)

**Specialty trainees: do you have an interest in communicating issues around mental health to the general public?**

**CAFPEB trainee reps needed**

The Child and Family Public Education Board (CAFPEB), chaired by Dr Virginia Davies, is looking for two ST4 – ST6 registrars to join the team of members, young volunteers, representatives from allied charities and staff working on the production of the College’s award-winning mental health information for the general public.

The Board oversees the development and production of resources for the general public which are increasingly needed in a wide variety of different media. It produces all the leaflets and translated materials for parents, carers and anyone working with children and young people, both in paper form and on the College website. These materials address a range of mental health issues covering different disorders, treatments, therapies and self-help.
Both appointed trainees will be need to be committed to the work of the Board for at least 18 months. You will receive consultant supervision from other members of the Board in taking forward any agreed new project.

Short-listed candidates will be interviewed on the afternoon of November 9. Please send a short letter and brief CV to tkennedy@rcpsych.ac.uk outlining why you think you would be right for the role, what you think you can contribute, and how much time you would have to commit to this.

Closing date for applications: 30 October 2015

Obituary for Steve Kingsbury

Ann York

My dear friend and colleague, Steve Kingsbury, died on 29th April 2015 aged 56. A child and adolescent psychiatrist, board game designer, Raiders and Chelsea fan, golfer and sandcastle builder, he retired from the NHS in June 2014; he wished to pursue his passion for mental health service improvement, golf and gaming and to spend more time with his loved ones. Sadly, his retirement was too brief; the following autumn he was diagnosed with a grade IV glioblastoma multiforme, the most aggressive form of the primary brain tumours. Much like Steve, his illness was an ‘outlier’; GBM only affects approximately 2-3 people in every 100,000 each year.

Steve was the eldest of two sons of medical parents. His mother is still alive and his brother is also a doctor. As a child, he spent happy holidays in the family caravan in Wales, and such holidays continued until very recently. As an adolescent he excelled in judo and was in the England team. As a young adult, he learned ballroom dancing. His physical co-ordination skills were something he loved to hone and in later years he became increasingly focussed on improving and changing his golf swing.

He entered Charing Cross medical school in the 1970s. Despite other students being quite green, Steve was not. As one of his old friends from that time said, “Steve always seemed to know what was happening. His picture was always the wood and not the trees.”

He always loved psychiatry and this is when I first met him; we were junior psychiatrists at St Bernard’s Hospital in Southall. He was the new person in the group but immediately commanded attention with his charisma, intellect and sparky wit. He flooded us all with his challenge, insight, creativity and a different way of seeing
the world. Steve evoked strong reactions in anyone who met him, even briefly, and they never forgot him.

He was massively into board gaming; as a young doctor he loved Dungeons and Dragons, played poker and Bridge, and began a regular board game night with some guys he met at a gaming convention. This weekly event, played late into the night, continued even when he was quite ill. As far as Steve was concerned, board games were complex, geeky (his twitter name was Stevethegeek101) and not only for playing. He designed them as well (City and Guilds, and King’s Progress), play testing them with his gaming mates. In the year before his death he had two new games planned.

After medical school he worked for a year in IT for the Medical Research Council and this experience was put to great use later in his career, both in coding and website design, but also in research.

He trained in psychiatry on the Charing Cross scheme and his experience working with young people and families rapidly turned into a passion to pursue this as his career. He worked at St Bernard’s Hospital, West Middlesex and later in Oxford. He naturally understood people at a very deep level and this, combined with an exceptional ability to cut to the chase and sensitively but robustly challenge, led him to be a highly effective and valued clinician. He was able to précis any situation into a short and highly accurate appraisal of the situation. He wrote the briefest but most pertinent clinical notes I ever read.

Full of one-liners, anecdotes, and dry wit, being with Steve was one of constant entertainment. But this was not all, Steve was a deep communicator who understood you, accepted you and wanted you to be your best, to cut through all the doubts and mess in your head, and follow your dreams.

He certainly followed his. Whilst still a junior psychiatrist, he met his wife Karen at his gym; they were both aerobics instructors. He often spoke with me of what a great team they were, their love of sport and bird watching (though how Steve ever stayed still enough to watch birds I’ll never know!). They went on to have two wonderful twins, Michael and Clare, who are now 18.

Looking after twins was full on, but Steve used his experience to help others and was an advisor to the Twins Club for many years, always ready to talk to other parents of bouncing duos. As a family they spent many happy holidays in their caravan in Wales, building sandcastles, for which, of course, Steve developed the perfect recipe for sandcastle mix!

During his higher psychiatric training at Oxford, he became very interested in suicidal behaviour in young people and published a seminal tool, still in use, called PATHOS.
It is described in a paper entitled ‘Message in a Bottle’. Steve’s ability to sound-bite the essence of communication is something everyone remembers.

Steve was appointed consultant child and adolescent psychiatrist at Hoddesdon Child and Adolescent Mental Health Services (CAMHS) in 1993, where he was loved by colleagues, young people and families alike. He was Clinical Director for many years and briefly Medical Director, passionate about making services the best they could be.

As well as this, Steve was Honorary Secretary for the Child and Adolescent Faculty and would organise juggling workshops to run alongside the more academic sessions at conferences, something everyone loved. He also developed a highly accessible newsletter, CAFE News. This exemplified another of Steve’s passions: acronyms (Child and Adolescent Faculty Executive News!). Fonts being another of them; he designed his own.

It was during these years that Steve and I began to work more intensively together again. We had many conversations about how teams functioned, how people worked together and how we wanted services to be the best they could. This developed from 2000 into what Steve often said was the greatest achievement of his professional career, the Choice and Partnership Approach or CAPA.

Never planned or marketed, interest in CAPA spread around the world; it was (and still is) so accessible and effective for services. Together we wrote four books, developed and hosted a website (capa.co.uk, all technical aspects managed by Steve) and monitoring and fidelity tools. At their request, we trained over 6000 staff all over the world. CAPA is now used all over the UK, New Zealand, Australia, Nova Scotia, Belgium, parts of the Netherlands and Ireland, in CAMHS and in adult mental health.

From 2006 to 2007 Steve was seconded to the Department of Health as Medical Advisor for CAMHS. Here, amongst other things, he developed quality standards for assessing services (You’re Welcome standards). His life at this time was full of CAPA, walking and cycling with his new partner Julia, supporting his children as they entered their teens, looking after his elderly mother with Karen and, of course, golfing and gaming. He continued to have annual golfing trips with his friends until the summer before he became unwell.

Following his retirement, Steve continued to work voluntarily for NHS England on the Children and Young People’s Improving Access for Psychological Therapies programme. He chaired a working group that developed quality standards for the associated service transformation, Delivering With, Delivering Well.
Having championed professionally for services to always be user friendly, collaborative, honest and strengthening, this is how he experienced the wonderful health services who cared for him.

He managed his illness with his usual dry humour, openness and acceptance. He once said all he could control about it was his attitude. He did not hide from anything and did not hide anything from others. His Raider flag, photos he had taken of beautiful places he had been, and an eclectic music mix adorned his room. He remained Steve until the end, even though GBM had claimed his physical co-ordination skills. He died peacefully with his loved ones around him on 29th April 2015.

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Contacts and leads within the executive

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

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<th>Name</th>
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In these times of widening gaps in society between richer and poorer communities, how can deprivation and poverty affect child mental health?

Abstract: The mental health of children in the UK is increasingly at risk, with rising numbers of hospital admissions for self-harm and suicidal ideation, and increasing numbers of referrals to Child and Adolescent Mental Health Services (CAMHS). Although the causal factors are debated, the link between poverty and rates of mental health in childhood has been demonstrated across countries and generations. The implications of changing economic circumstances, across Europe especially, has raised concerns regarding child development and well-being. The evidence that a growing economic inequality in the wealthiest countries might exacerbate demands on mental health services in and outside the UK has not been adequately explored. Suggestions made that widening gaps between rich and poor play a fundamental role in determining levels of childhood psychological and emotional development are, therefore, yet to be substantiated. Public health initiatives to improve identification and management of at risk children through primary prevention might hold the key to improving their long-term outlook. Our understanding of the predictive and protective factors that govern the risk stratification for mental illness in children will be central to the directed efforts to halt the rise in prevalence across the UK.

Essay: The inverse correlation between socioeconomic status (SES) and risk of disease that is exhibited in societies across the world is unquestionable. Links between poverty and poor child health follow a similar pattern across counties and time, described by World Health Organisation (WHO) as being ‘extensive, strong, and
pervasive’. The stratification of mental and physical disease risk of children based on even subtle socioeconomic differences poses a significant public health issue. In the light of morbidity surveys showing the two week prevalence of anxiety and depressive as over 15% (1), mental illness is more commonly acknowledged as having a significant health burden. Despite this, the effect of socioeconomic circumstance on child mental health are only recently coming into public awareness. Although there has been growth in the understanding of the environmental determinants of psychiatric illness as a whole, understanding of child mental health and its psychosocial determinants is still shrouded by public misperception and inadequate research efforts.

This essay hopes to discuss the implications of changing economic circumstances, widening gaps between the wealth and poverty of the UK and wider world, changing family dynamics, and increasing levels of deprivation on the mental health status of the population of children predominantly in the UK. It will touch upon the effects of poverty both on the individual young person, the family group, educational and social institutions and society as a whole. These will all be discussed in the context of a clinical case, exploring the development of mental illness in a 15 year old girl called Sarah (a pseudonym).

**Clinical Case:** Sarah is a 15 year old Caucasian girl who is known to CAMHS since the age of 11, presenting with high levels of anxiety, longstanding in nature, the most prominent of which being separation anxiety, generalised anxiety, and OCD tendencies. She experiences numerous maintenance cycles of worries and fears, catastrophic thinking, generally surrounding harm befalling her mum, which has led to non-attendance at school and transition to a specialist teaching unit. Her mother described that Sarah showed signs of distress as a small child if they were separated, reduced responsibility for personal hygiene and hyper-vigilance in her environment such as worrying about making mistakes, and how others will perceive her. She has health anxieties due to a diagnosis of Wolf-Parkinson-Wight syndrome, exacerbating some obsessional behaviours, including repeated checking, turning lights on and off, and dressing in a certain order. She developed low mood aged 13, particularly at night with peaks of suicidal ideation, but never had any active plans, and this evolved into significant depressive features more recently.

She is an active, well dressed girl, who is able to maintain eye contact and can develop a reasonable rapport. Sarah is the youngest of three children. She lives at home with her mother, who works part time as a nurse, her elder sister and her two year old child. Her step-brother was taken into care before she was aged 10 due to conduct disorder. She has no contact with her father. Her childhood was complicated by a move to a teaching unit due to inability to cope in mainstream
school. Additionally, she has had major surgery to repair a mitral valve prolapse, after which she developed sensory hypersensitivity which exacerbated sleep difficulties. Her treatment for low mood and depression has included sertraline, clomipramine, and fluvoxamine, each discontinued due to disinhibition and concerns regarding behaviour at school. More recently she was treated with citalopram and later fluoxetine and has had psychological input and family therapy to improve family relationships and tackle anxiety around separation. Sleep difficulties have been treated with circadin.

**Poverty and the Social Context: why ask the question?**

March 2015 brought the publishing of figures describing the widening gap between rich and poor in UK, showing a 64% increase in wealth of the highest incomes, and a 57% decrease in the lowest between 2005 and 2012 (2). The WHO has marked poverty as the greatest cause of suffering on earth (3). Every second child, totaling one billion, is understood to live in poverty, a trend reflected in the rates of poverty and socioeconomic distribution of the population of the UK. The Joseph Rowntree Foundation, established to inspire social change, reported in 2014 that 13 million people in the UK were living in poverty, and although child poverty rate seems to have improved, the working-age poverty rate has increased over the last decade (4). Lowering levels of pay, including a drop in pay for the lowest paid 25% of the population, and adjustments to the welfare system in recent years have resulted in worsened experiences of poverty for those affected. Despite the efforts of charitable agencies and government aid projects globally, the problem of poverty and widening wealth gaps is only becoming a larger one. In 2007, 80% of the world’s population lived in a country where the income differentials were widening (5), giving the top 0.13% of the global population control of close to ¼ of the world’s financial assets (6). These trends are only set to get worse, as the wealthier nations on earth demonstrate the widest gaps between rich and poor (7).

Already, the WHO recognises that the social and economic impact of mental disorders is diverse and far-reaching (3). In fact, there is a growing contribution of mental health problems to the global burden of disease, as neuropsychiatric disorders now account for 13% of the total (8). The links between poverty and mental illness are well characterised; children and adults with a household income in the lowest 20% are three times more likely to have common mental health problems than those in the richest (9). This begs the question of what the implications are for mental health prevalence of rising economic inequality and deprivation. Childhood illness is known to have long-term ramifications on development and well-being, worsening a cycle of poverty and lack of social mobility. It is crucial that management of childhood mental health can be improved to increase the resilience
Indices for Poverty and Child Mental Health: how do we define and estimate?

Deprivation is defined in the Oxford dictionary as ‘the damaging lack of material benefits considered to be basic necessities in a society’, and as such considers inequality and the culturally determined lifestyles of the majority. Most commonly equated to ‘material deprivation’ in psychology, it has been hypothesised (in the extreme) to be associated with aggressiveness, depression and even affection-less psychopathy (10). Although this hypothesis has been widely debated, it demonstrates the depth of discussion surrounding material inequality and its implication for society. Poverty, on the other hand, is associated solely with material possessions or money required to live, and considers less relative wealth and possession.

Both poverty and deprivation have been equated in research and literature, on the whole, to SES, a determinant that is calculated with an array of factors related to the individual, family and society someone lives in. This is therefore a useful estimate, especially in children (11), but is variable dependent on the method of calculation. Most include some quantification of family income, parental education or marital status, and occupational status as a baseline (12). The Family Affluence Scale (FAS) is a standardised measure used in a range of studies to measure adolescent SES, using car ownership, own bedroom, family holidays, and computer ownership (13), a scale that is only relevant, therefore, to young people in the developed world. Other markers of deprivation in child groups include attending a disadvantaged school, living within a deprived neighbourhood, parental unemployment and increased family size (14). The diversity of measures to estimate SES make the comparison of international epidemiological studies challenging, and influences the clarity about research surrounding deprivation and mental health.

Socio-Economic Background and Mental Health

Poverty has been described as ‘intrinsically alienating and distressing’, removing both ability to satisfy basic needs and control of resources (15). Coupled with the additional associations with poor health and lack of education, the implications for mental health seems bleak. The associations between poverty and mental health have been deeply investigated, leading to the formation of two major theories linking SES and socio-emotional adjustment, namely social causation, which adopts poverty as the causal factor in the development of mental health illness, and social selective drift. The latter proposes that cycling of stigmatisation, reduction in
support mechanisms, and incapacitation characterises a drift of both those with mental health problems into poverty, and those in poverty into risk of both poor general health and admission to psychiatric hospitals. This association has been broadly characterised in adult populations, but the correlation for child mental health is less clear.

The identification of further proposed indicators of future psychiatric morbidity, including financial strain and debt, have challenged these mainstream arguments. One study showed that the relationship between mental disorder and poverty was attenuated significantly by the adjustment for levels of debt. Prospective birth cohort studies have cited SES deprivation as the prime issue affecting child ‘well-being’ (16). Furthermore, increasing levels of inequality alone have been related to decreasing health status and reduced life expectancy, as described by Wilkinson’s psychosocial stress model created in 1997. It is possible that similar forces will effect mental health through the mechanisms proposed by Bradley and Corwyn, namely environmental resource limitations, psychological and psychosocial influences.

The correlation of these factors with levels of child mental health are again difficult to classify. It is true that children living in a low income family are at more than three times the risk of developing mental health problems compared to those living better off (17). This relationship is particularly stark in boys, who are more likely to be diagnosed with ADHD, have uncontrolled bedwetting, and develop self-harming behaviours. Furthermore the relationship between poverty and mental health is stronger in children than in adolescents (18). Despite this evidence, explaining the link between poverty and mental health is more impenetrable than in adults. In fact, no variables consistently correlate with every mental health disorder (14). These complex interrelationships make understanding the aetiology and pathogenesis of various forms of mental illness in children very difficult.

The common markers of disadvantage, including attendance to a disadvantaged school or parental unemployment, have been shown to be not independently associated with disorder (14). Emotional disorders, such as the anxiety experienced by Sarah, are much more likely in children who have experienced poor general health and distressing life events, whereas conduct disorders are more distinctly associated with family variables, such as large family size and parental unemployment. Furthermore, diagnoses commonly linked with poverty and low SES such as ADHD, were shown to be correlated much better with child characteristics, and not life events/general health or family variables. As a result, it is increasingly understood that predicting child mental illness is more accurate when the child and family are individually assessed, not using aggregate measures of school and neighbourhood.
In common with the age-long nature vs nurture debate, genetic influences over the development of mental health problems is thought to play a role in children and adolescents, further clouding the waters of the relationship between poverty and mental illness. Of the disorders exhibited by Sarah, many of them have been described to be brought about through interaction between genes and environment. Research has suggested that separation anxiety disorder may be substantively influenced by environmental factors, to a greater extent than other childhood anxiety disorders (19). Anxiety and mood disorders were both linked to heritability and environment in children, although variation existed between ages (20). As such, a global consortium has identified gene-environment interactions in risk factor determination for mental disorders as one of the many ‘grand challenges in mental health’ (21).

The prevalence of child mental health problems and cases like Sarah’s seems to be worsening. Research indicates that the onset of depression is occurring earlier in life today than in past decades and often coexists with other mental health problems such as chronic anxiety and disruptive behaviour disorders. Of the youth in America in 2002 (aged 13-19), it was estimated that 28% would experience at least one episode of major depression (22), and in the UK over the last 25 years, rates of depression and anxiety among teenagers has increased by 70% (23). Up to 1 in 12 children in Britain deliberately hurt themselves on a regular basis; this is the highest rate in Europe (24).

Implications of Poverty and Deprivation

- Effects on the Child/Adolescent and Family

Causes of mental health problems in the general public are wide and variable (24). Biological factors such as genetic predisposition and the effects of illicit drugs interact with social influences, such as fragmented communities and low levels of housing, as well as psychological factors, including insecure attachment to parents in infancy, bullying, and family breakdown, to modify the risk at an individual level. In children, poor parental mental health and parental unemployment dramatically increases the risk of emotional or conduct disorder, whereas adverse childhood experiences increase the risk of mental illness and substance abuse. The long term ramifications of these factors are significant, as mental disorder in childhood and adolescence leads to a broad range of poor outcomes in adulthood, such as lower educational outcome and earnings, teenage parenthood, mental illness and criminal activity (24).
Increasingly research has shown that, in the context of a low family income, disruptive demographic factors and sparse support mechanisms generate the distress that increases risk of psychiatric disorders in childhood. A meta-analysis of composite measures of SES have shown small but significant effects on literacy and language, aggression and internalising behaviors including depression (11), giving evidence for the widely held belief that the sequelae of a lower SES can have an adverse effect on child well-being. An earlier study concluded that lower socioeconomic status leads to a poorer social, emotional and behavioral outcome (12). Thought to be as a result of adverse effects on participation in social, leisure or fashion and grooming activities, lower SES leads to a reduction in friendships and self-esteem, leaving a child to feel ashamed and excluded (25).

Investigations into experiences as a child and later mental health have shown an increased risk of psychosis, with high scores in measures of social adversity as a child, such as economic difficulty, single parent households (24). This is exhibited also in immigrant populations who, as well as experiencing on average lower SES, have been shown to experience poorer health outcomes over time when compared to the general population (28). Similarly, adults brought up in first or second generation immigrant families experience increased risk of psychosis, as revealed by the East London First Episode Psychosis Study (29), and as such schizophrenia has been highly correlated with a personal or family history of immigration (30). Studies have shown that associations lie between psychosis and perceived discrimination, family dysfunction, high unemployment and poor housing in children from immigrant populations, suggesting a link with low SES (31).

Evidence has shown that that persistent poverty is a greater predictor of internalising symptoms such as childhood depression, but on the other hand current poverty is more strongly associated with childhood behavioural disorders. It has been noted that this may be due to long-term parental stress and its implications for parent-child interactions (32). One study showed that the effect of initial household income on the rate of depression attenuates over time, whereas antisocial behaviour becomes more severe with time after an initial low income experience (27). There is also evidence that increased frequency of child exposure to poverty is a consistent predictor of adolescent anxiety and depression. Repeated exposure increases the likelihood of mental health problems (33). Despite this, a Cochrane Review showed no benefit for child mental health of financial benefits for low income or socially disadvantaged families (34), although the study was limited by small monetary values.
Although low socioeconomic background has been inextricably linked to an increased risk of childhood mental illness (see Figure 1) (35), untangling the causal factors associated with these two variables is difficult. Studies have shown that a distressed marital relationship during the child’s first five years of life can account for an increased risk of high anxiety and depression symptoms in adolescence (36). Research has shown divergent results of the effects of living in a single parent household (36, 17). Additionally, marriages within lower SES communities were at increased risk of separation and divorce, and experienced reduced levels of satisfaction and happiness within the romantic union (37), a possible cause of disturbance for children of the family. Extrapolating these findings to the study case, Sarah experienced a marital breakup before the age of 5, and may therefore have experienced psychologically damaging circumstances that put her at increased risk of mental disorder, exacerbated by low SES.

Neglect has been raised as a significant contributor to child mental health levels. Neglect is known to hinder psychological as well as physical development, as described by neuro-affective relational models. It results in distortions of identity such as shame, chronic self-judgment and low self-esteem, and low capacity to connect to self and others. Unfortunately, there is evidence that child maltreatment is more likely in communities with high rates of poverty. The WHO directly links a child’s vulnerability to neglect and abuse, to a low SES status (38). Household overcrowding, and lack of income to meet family needs are variables used to show increased risk of neglect, the sequelae of which have been described as drug and alcohol abuse, eating and sleep disorders, post-traumatic stress disorder, depression, anxiety, suicidal behavior and self-harm. It is likely that long-parental working hours and an overcrowded house may therefore have increased Sarah’s likelihood of developing mental illness. Among low-income families, family exposure to substance use resulted in the highest rates of child abuse and neglect (39), providing further evidence that parental mental illness has more than a genetic effect on offspring.

The interaction between a child and family in poverty and mental health has implications for all members. Mental health issues within the case study family led to family disruption and reduced stability. The removal of a child into care, a procedure carried out more commonly in lower SES families, has been shown to increase levels of mental health difficulty in the child and their siblings. Furthermore the
development of separation disorder affects the relationship held between Sarah and her mother, reducing the likelihood that further positive role models could be formed and increasing maternal anxiety. Measures of maternal depression have been shown to be strongly predictive of child mental health problems, controlling for many other factors (40). As a result, cycling family disruption and mental health issues incapacitate this family, exacerbated by reduced social support and financial difficulties.

**Wider Context of School and Nursery**

For Sarah, the issue of separation anxiety is difficult to manage, and has significant implications for her social and emotional functioning, preventing her from exploring new relationships and gaining new confidence through activities in school and in her leisure time. Separation anxiety is considered a normative part of early childhood, promoting anxiety related behaviours and parental care in babies and young children. This behaviour usually disappears by the 2nd or 3rd year of life, but if remaining persistent is a good indicator of mental health disorder. It is characterised by an abnormal reactivity to separation from attachment figures that significantly interferes with normal daily activities (41). Epidemiological studies have gauged the prevalence of SAD at 4-5% in children and adolescents (42). Interestingly, the prevalence within low income families is significantly higher, estimates ranging from 50-75%. As in Sarah’s case, symptoms are recognised most commonly in school-refusal or somatic symptoms associated with school attendance. Although some of the common precipitating factors for SAD, namely losses such as parental divorce, death of family member, or a move to a new home or school, as well as stressors like peer relationships, can be found in a higher proportion in low income families, they are not exclusive to them. This implies that there may be additional factors that control the relationship between family economic circumstance and development of this disorder. For example, Sarah’s mother was described as demonstrating an overprotective parenting style, a known risk factor for SAD.

The link with SAD and other anxiety disorders is still widely debated, with a number of longitudinal studies suggesting that childhood SAD may be a risk factor for further anxiety disorders, including depressive disorder, panic disorder and obsessive compulsive disorder (43, 44). Research in attachment theory has consistently found that attachment styles demonstrating insecurity or anxiety can lead to emotional disturbance and psychopathology, including behavioural problems and depression (45). In Sarah’s case, the development of obsessional thoughts drastically destabilised her daily activities, limiting her attendance at school and interaction with peers. Obsessive compulsive disorder, an anxiety disorder characterised by disturbing thoughts, impulses or images, which can lead to repetitive or ritualistic
behaviours, has been linked to lower SES in children (46), as well as lower intelligence. It is understood to interfere with the ability to play, socialise, attend school and function as a family (47), increasing the likelihood of social exclusion and isolation. This trend is mirrored in other countries, with poorer children in Greece reporting higher levels of anxiety disorder-related behaviours in school (48). Relationships like this put greater weight to the argument that mental health development in children is causally associated with low socioeconomic background and deprivation.

- **Implications for Society and NHS**

It is possible to see the implications of poverty and associated mental illness for society by looking directly at police figures. A report published by Prison Reform Trust showed that over 90% of prisoners detained in 2009 had one or more of the five psychiatric disorders studied, including psychosis, neurosis, personality disorder, hazardous drinking and drug dependence (49). These figures indicate an issue of childhood as well as adulthood, as 50-60% of adults with a mental disorder have received a mental health diagnosis of some kind before the age of 15 (23). In fact conduct disorders are the most common childhood psychiatric disorders; prevalence as close to 5% of all children aged 5-10 years old (9). Research has suggested that opposed to poverty alone, income inequality can result in the stress, frustration and family disruption that may increase the rates of crime, homicide and violence of the child in later life (50).

Although the Cambridge Study in Delinquent Development concluded that poverty did not predict delinquency in adolescent males, good mental health was a predictor of long term success in this group (51). Boys who began committing crime as a child went on to be the most prolific offenders in adulthood, and separate evidence shows that conduct disorder results in adulthood antisocial personality disorder in a high proportion of cases (52). Poverty and the neighbourhood context both increases the risk of becoming a victim of family violence (53), and influences the levels of impulsivity which may drive someone to offend (54), highlighting that social forces, perhaps economic inequality, can better explain the development of antisocial behaviour. As exemplified by the case study, despite a supportive and loving mother, children born into low SES families are more likely to develop conduct disorders, which may have wider ramifications on the mental health of siblings and the general community.

Rising levels of poverty are likely to continue to increase demand for mental health services in the NHS. Although formal figures are no longer published, Sarah’s situation is not an uncommon one and it is widely understood that levels of
admission to A&E for mental health issues are climbing. As discussed, there is evidence that a wide number of mental health disorders correlate with social background, and with the discrepancies between rich and poor growing, the NHS must adjust mental health service capacity. This will include the treatment of anxiety and mood disorders as experienced by Sarah, as well as alcohol and drug misuse and conduct problems. This problem is one which permeates society, which increasing strain on community organisations and charitable groups such as the Samaritans, the NSPCC and ChildLine, who reported a 34% increase in counselling for mental illness such as depression and panic attacks in 2013/14 (55).

**Future Directions**

This essay has shown that complex interrelationships exist between the circumstances of the family, their mental health and the mental health of a child, in the context of socioeconomic background. Evidence that those with mental illness might recover better in developing countries, where there is widespread deprivation, than in developed countries, has encouraged debate about methods to improve treatment for those with mental illness (56). It has been proposed that efforts should be made to identify the protective qualities that give resilience, despite adversity, to overcome these disorders (57). Factors implicated include family and social support networks as well as individual personality traits. Sarah’s case shows that, despite early intervention, mental health services are not able to halt the escalation of mental illness in many cases. Further research will be required to accurately identify at risk children, and then to find effective management strategies to improve outlook long-term. As proposed by a Lancet article, the improvement of population health would only be possible with the identification of prevention and treatment of mental disorders as a public health priority (58).

The WHO advocates many approaches to prevent child abuse and neglect, including measures to tackle poverty, improve educational and employment opportunities and increase the availability and quality of child care (53). They call for training in parenting and home visitation programs, to improve child-rearing, parent-child relationships and the family environment. Parenting and school-based emotional learning programs have also been shown to reduce a child’s later burden of criminality on society, supporting the role of family education and social factors in the development of conduct disorders and later participation in the criminal justice system. The BELLA study in Germany has shown that mental health risk stratification can be carried out using factors related to the socioeconomic circumstance of the child to better target resources in treatment (59), from resource strengthening to risk reduction in those at high risk. Current NICE projects aim to provide guidelines on the identification and management of mental health problems and integration of
care for adults in contact with the criminal justice system (60), which may improve the outlook for any children within their care. It is clear that a multi-faceted approach will be required to alter the course of child mental illness. It is possible that alongside treatment of the child and family, modification of the risk factors so often associated with social deprivation might short-circuit a viscous cycle of poverty and mental illness, improving the long-term as well as short-term prospects for children like Sarah living with mental illness across the UK.

References available on request

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