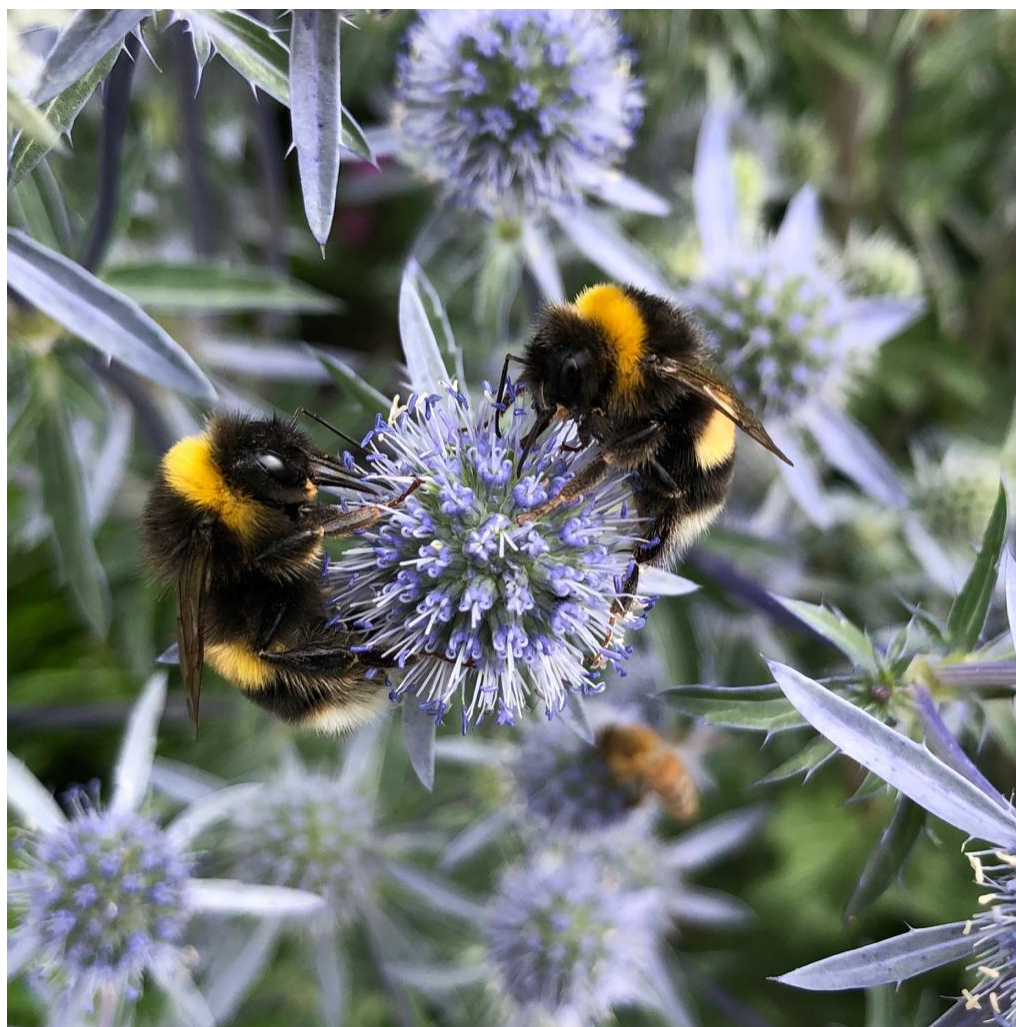


***Faculty of Child & Adolescent Psychiatry Executive Committee
Newsletter***



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David Williams, DH Welsh Assembly

Richard Wilson, Faculty in Northern Ireland

In this issue**Virginia Davies**

Welcome to our summer newsletter. I've chosen a picture of bees as my seasonal image. Like us, they need to work collaboratively to achieve their ends, and, like us, their jobs entail careful probing and cross pollination (in our case, of ideas across the networks within which CYP exist).

In this edition, Bernadka reports on her work with our European partners. It's great to hear how well regarded is our child and adolescent psychiatry training across the rest of Europe, and such a shame that we now have to contend with the ever-worsening effect of Brexit on the recruitment and retention of other Europeans to/in this country. Social media crops up again in her work, and yet again she has been out ensuring that this bogey man image is not used to detract from government's responsibility for the much more important drivers of health, including mental health, ie poverty. Do respond to the College's draft position statement on social media.

Both Wales and Northern Ireland have been working across divides, with Wales coming together with their adult colleagues to plan their first ever joint meeting - spurred on by the Welsh government wanting to see improvements in transitions - and Northern Ireland getting together across the North South divide to bring all child and adolescent psychiatrists across the isle together to think how to support each other and share learning opportunities. Catherine Gillanders furnishes us with a detailed report on this day.

Scotland is in the midst of departures and retirements with the loss of a key ally, Dr Dame Denise Coia, who had to step down from the Children and Young People's Mental Health Taskforce due to ill health, and the retirements of several consultants. Understandably recruitment is on Elaine's mind.

We have an absolutely brilliant article from on mentoring. It really made me think "Why on earth aren't we doing more of this?"

Birgit summarises all the important outputs being achieved through the various collaborations we're managing to forge at the Paediatric Liaison Network, and Suyog updates us about where things are at with the Curriculum Review and the run-through training (all good stuff).

Priya and Priyanka highlight the upcoming College Child and Adolescent Psychiatry Trainee Conference in Birmingham. The deadline for abstract submissions is 30th August 2019.

As CAFPEB chair, I'm particularly excited by Carla Duncan's report from Blackpool on the first young people's debate to be held there. We started with these debates in London only, then Wales took the bull by the horns and set up their own debate and diversified the model, and now a non-College centre has taken the model and run with it. Like mentoring, these public mental health interventions could

easily be scaled up if sufficient local goodwill is harnessed to mean they can be run out of local authority buildings with local child psychiatrists getting involved. Professor Alka Ahuja and Vasu Balaragu are the people to contact if you'd like to run a debate near you. Why not have a go?

We have a rigorously argued response to Peter Hindley's letter in our Spring newsletter. Professor Helen Minnis furnishes compelling arguments for why diagnosis is absolutely vital in babies and young children. How many of us feel sure we would always spot and take action on 'frozen watchfulness' and 'failure to seek comfort'? How many of us even see children of this age? (I'm thinking about the decimation of under 5s services). How many of us supervise or have any contact at all with health visitors or nursery staff seeing children of this age? It left me feeling that more conversation has to centre around this age group and who is keeping an eye on them. Increasing self-harm in emergency departments, unmet need for diagnosis of autism spectrum disorders and failed transitions are crowding out the dialogue.

Finally, the results of the Medical Student Essay Prize are in! Read Ellen Macpherson's excellent winning essay on the subject of self-harm.

Dr Virginia Davies

Editor

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The chair's column



Bernadka Dubicka

In the midst of our impending exit from the EU, I have had a notably European few weeks. Our Faculty has been a member of the European Society of Child and Adolescent Psychiatry (ESCAP) for some time, but as a rather passive member with little involvement to show for our annual subscription (incidentally one of the lowest fees in Europe as this is based on the size of our membership which unfortunately is pretty much towards the bottom of the European league – 21st out of 28 countries).

In light of our EU divorce, recent dependence on a European workforce, potential fragmentation of our collaborative European research projects, and for many other good reasons, I thought that it was important that we were represented at the annual chairs' meeting. It's fair to say that my appearance in Vienna took some of our partners by surprise (Ireland: it's great to finally hear a UK voice here), but I was also pleasantly surprised: it was really inspiring to hear what's going on with our neighbours, and I was warmly welcomed. As has been repeatedly said since the tragic death of Jo Cox, there really is far more that holds us together. Issues of our identity were much discussed (in the Netherlands child psychiatry now sits in social care), as was the idea from many policy makers that prevention is the cure for all mental health disorders, and that our jobs will be redundant with sufficient input into prevention (the College has consistently argued for resource along the whole pathway, recognising the likely increase in demand if more disorder is recognised in the community). The ESCAP board has clinical, academic and policy sections and this offers excellent opportunities for developing joint strategies that can benefit all of us. For example, the next task of the policy group is to produce a statement on children's rights: there are important issues for discussion such as the age of criminalisation, which remains scandalously low in the UK (8 in Scotland and 10 in England and Wales). Such joint guidelines/statements can give us helpful leverage for effecting change in the UK, and if we are not sitting at the table, we don't have the chance to influence.

I also attended the ESCAP conference and presented at a couple of symposiums. Training and workforce were key themes and again it was notable how we and our other European colleagues struggle with many similar issues. On a very positive note, both Professor Dame Sue Bailey and Brian Jacobs have been instrumental, together with the College, in leading the way on training, and our training is much respected in the rest of Europe. Both Sue and Brian have worked tirelessly through the Union of European Medical Specialties, UEMS (Sue is the president) which has raised our profile in Europe. As they are standing down soon, it will be important for others to continue these ties with Europe and promote all the good work that we do. For example, I have shared our document on the role of a child psychiatrist, as the issue of our identity remains key, and also our document on understanding the values of children and young people. I was struck by the lack of any service user

involvement at the conference and perhaps this is another area where we can disseminate some of the excellent participation work that is being done in the UK.

I was also invited to speak at the European Federation of Psychiatric Trainees (EFPT) last week, where I talked to trainees who are planning to take our CASC exam and are considering coming to the UK. Whilst we continue to struggle with our workforce, opening up opportunities to some of the excellent European trainees I met would enable their valuable contribution to our services.

The topic I was asked to talk about to the European trainees was social media. This subject continues to dominate the media (unfortunately at the expense of important drivers of mental illness such as poverty), and we have recently responded to the government white paper. Our line is that although social media is not a primary driver of mental illness, it can exacerbate existing inequalities in vulnerable groups, and that the content and context of social media use is more important than screen time alone. There needs to be more high quality research which looks at the complexity of interaction between vulnerable young people and screens, including how we can harness the benefits. We welcome the broad range of the white paper and the proposal for an independent regulator, although there needs to be considerable stakeholder involvement regarding the powers of the regulator, and consideration of unintended consequences. I also think there is a lot of room for 'nudge' tactics to influence societal change - full marks to Frankie and Bennies for offering free meals to kids if families have tech free meal times. Our tech paper is in its final draft now, and due for publication early autumn; thank you to those of you who got in touch with your views.

I attended a panel debate with Barnardos, at the launch of their publication on social media and vulnerable groups. Our joint concerns are therefore very similar and I was pleased to support their event and to work together to highlight inequalities. The current health secretary Matt Hancock also spoke and announced funding for joint work between the Samaritans and social media companies, so important conversations are happening.

On a positive note in relation to manpower, NHS digital reports increasing numbers of non-training grade specialty doctors. I have had the pleasure of working with some excellent specialty doctors who have been a real asset to our services, and for personal reasons have decided to defer applications to higher training schemes. We need to support and encourage these valuable doctors to continue to work with children and young people.

The other area where we continue to be successful with recruitment is the run-through training scheme, which remains very popular. We now need to build on these successes. One area I am keen to look at is the variability in numbers of child and adolescent psychiatrists around the country. I would like to understand how and why some areas are better able to recruit and retain at all levels, so that we can share good practice across the UK.

One other piece of good news in relation to CAMHS manpower more generally: NHSE announced this week that a further 123 mental health support teams will be rolled out in 57 areas of the country over the next year, on top of the existing 59 teams. This can only be a good thing, although I appreciate that it will be some time before these teams start to have an impact on your services. Please do let me know via Stella how these teams are working in your areas.

Finally, if social media and technology are your thing, then please come along to our conference in Belfast, where we have some cutting edge speakers talking on this topic (check out Joseph Firths

recent review on the effect of the internet on the brain in *World Psychiatry* June 2019). If that's not your thing, then we have other great symposia lined up, such as ethics in practice, the role of inflammation, infant and youth services, including findings from the EU Milestones study, to name but a few. And there's always the Titanic...I look forward to seeing you there.

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Report from Wales



Amani Hassan

We are busy in Wales preparing for the first ever joint meeting between the Adult Faculty and Child and Adolescent Faculty. The idea was always there, but the catalyst this time was the interest of both Welsh Assembly Government (WAG) and the Children's Commissioner for Wales in transition. The meeting will be held on the 6th September and the theme will be Transition. So far we are considering academic and national speakers. The meeting will be focusing on serious mental illnesses such as eating disorders and early onset psychosis, since effective transition plays such a major role in ensuring continuity of care.

I am regularly attending the Whole School Approach to Mental Health and Wellbeing Stakeholder Reference Group meetings (SRG) arranged by WAG. The chair and attendees agreed that the work should not be skewed towards adopting a medical model in tackling mental health issues. While we are still discussing and drafting a framework, WAG has secured the money to implement the future proposed work. It was confirmed that £2.5 million of recurrent funding has been secured for the programme.

I attended the joint spring meeting between the Royal College of Psychiatrists in Wales and the Welsh Psychiatric Society held at the Dylan Thomas Centre on Friday the 14th June. A big congratulations to one of our medical students, Francesca Welham, for her excellent poster, which came second. The poster highlighted an audit of the CAMHS learning disability tertiary service practice against the national Stomp Guidelines.



Pictured Professor Keith Lloyd President of the Royal College of Psychiatry (Wales) with Francesca Welham, 4th year medical student, Cardiff University.

Dr Amani Hassan
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Report from Scotland



Elaine Lockhart

At the time of writing this, the sun is shining in Scotland and the schools are about to take their summer break. This seems to create the double task of responding to children and young people with complex mental health disorders while either preparing to go on holiday or covering for our colleagues who will be away. This may place me in the role of the summer version of the Grinch, but hopefully we will all get a decent break over the summer!

The Scottish Government work with the Children and Young People's Mental Health Taskforce continues, but we were very sad to hear that Dr Dame Denise Coia has stepped down due to ill health. Her personal attributes and professional leadership will be greatly missed, and the future direction of the Taskforce is subject to ongoing discussions. In the meantime, we are working on the development of a referral proforma to CAMHS, shared care protocols and physical health monitoring for our

patients, along with the other work of the different work streams. We are also keen to support the work of the newly established Perinatal and Infant Mental Health Board.

Several consultant colleagues are retiring this year and new posts have been created in Lanarkshire. Although very welcome, it will be a challenge to fill all these posts. In the meantime, referrals to CAMHS are continuing to increase. This is alongside increased requirements from the national data system and Health Improvement Scotland, which will hopefully lead to increased capacity and efficiency within services, but in the meantime means colleagues are very much under pressure.

Our Vice-Chair, Dr Aileen Blower, worked with John Crichton and College officers, in crafting a letter to MSPs, as well as press statements, regarding the Age of Criminal Responsibility legislation. A well-meaning but unmanageable amendment had proposed that all young people referred to the Reporter (part of the Scottish criminal justice system for children under 16 years) should be assessed by a child and adolescent psychiatrist. This was dropped when the practicalities were spelled out clearly by colleagues.

Three Health Boards bid to host an LD CAMHS inpatient unit. Lothian were chosen to take forward plans to the next stage. This will be for an adolescent LD CAMHS unit, with the National Child Psychiatry Inpatient Unit being adapted to be able to take all under 12s with LD requiring inpatient psychiatric admission.

In addition to the investment in these units, work across Scotland will also be required to ensure robust pathways are developed to support appropriate referral and repatriation of these patients. It will be really important that this development is used to develop community LD CAMHS services.

Media interest continues and the appointment of a Media Officer, Laura Varney, has resulted in coverage of mental health and an opportunity to spell out what children and young people require across services.

Wishing you all a relaxing time at some stage over the next couple of months.

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Report from Northern Ireland



Richard Wilson

The Spring is a vibrant season, always full of new hope and vitality. Accordingly, refusing to be deadened by the chronic political crisis Northern Ireland, child and adolescent psychiatrists continue to bring news of a difference. Dr Catherine Gillanders' reports on the incredibly positive reception we had in Dublin on our invitation visit on 29 March 2019.

It was great to catch up with old friends and meet many more new ones! Our aim was to rekindle professional links with our counterparts in the College of Psychiatry of Ireland. After much constructive discussion, which continued over an excellent lunch at the Aisling hotel, foundations are now laid to re-establish connected learning on a whole Island basis both for our trainees and all College members. This will be energised at the All Ireland Academic Conference which is being hosted in Belfast by RCPsych Northern Ireland in November!

Reenergised, rather than daunted, by the sudden announcement in April that the Deprivation of Liberty (DOLs) section of MCA 2016 is to be launched in November 2019, the Faculty has been in active discourse with the Department regarding both the practical aspects of implementation and the finishing of the legal changes (and very real challenges) for under 18s and their families. As Professor Terry Carney, Head of the Faculty of Law, University of Sydney, who is a world authority on Children's law & rights said to me last year, the proof of this pudding will be decided by the eating.

I am pleased to report that our joint Child Psychiatry/Paediatric Conference 2019 proved successful with yet higher attendance and positive feedback. Our theme this year was the challenges to mental health and well-being of long term physical and mental illness. The keynote address this year was



delivered by Professor James Walters, who totally stormed the room with his presentation on the astounding recent advances in genetic research and their implications for mental health theory and practice. This memorable talk was supported by presentations on childhood cancer, diabulimia and diabetes distress, seizure syndromes and CAMHS/ID developments. Aside from James' brilliant exposition on his copy variant research, I think I shall always remember the talks given by our two stars, Lauren Friel, trainee occupational therapist and Amy Dickson, paediatric nurse, pictured, who retold their stories of recovery with such passion and verve.

Our audience of doctors, nurses, psychologists, social workers and senior service managers and even two small birds (illustrating phenotypic diversity) were deeply grateful to the Northern Ireland Children's Health and Social Care lead for her attendance and participation at this event.

Now if you're looking for a high-quality educational experience yourself we would be glad to welcome you to Belfast on 26th and 27th September 2019. Professor Helen Minnis and the academic guys have put together a wonderful programme. Professor Elena Garralda will be starring and booking is now open....



Royal College of Psychiatrists [Faculty of Child and Adolescent Psychiatry Annual Conference](#) Thursday 26 – Friday 27 September 2019 Belfast. I hope to see you all there!

Finally I would commend you to read the excellent article also in this edition of the Newsletter by an Expert by Experience. We hope to write up in more detail our experience of developing a Patient Mentorship Programme and stimulate further development and research in this area of practice.

See you all in Belfast September....don't forget the early bird (more birds Bernadka!) booking rate!!

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Psychiatrie sans frontières.....Ireland

Catherine Gillanders

29 March 2019: Giving practical effect to our aim of working together, Drs Richard Wilson, Hilary Boyd and I travelled to Dublin to take part in a Royal College of Psychiatrists of Ireland Child and Adolescent Faculty meeting.

We received a very welcoming and hospitable reception from the Faculty Chair, Gerry McCarney and were delighted to see a number of consultants who had trained in Northern Ireland in attendance.

Discussions focused initially on service provision North and South, in particular the emerging establishment of crisis response team services in the North and specialist eating disorder services. North and South's increasing demand for Step 3 CAMHS services related to autism spectrum disorders was noted, and recognition given to the need for future service development to be based on best evidence, as well as regional considerations. Both Faculty chairs recognise the learning that could be gleaned from local practice, and good foundations were laid for a developing relationship.

Dr Wilson described the supportive training and professional development opportunities in the North, as well as the excellent retention rates in consultant posts. These arrangements are regarded highly by consultant colleagues in the South.

I talked about the previous collaborative specialist trainee / SpR teaching across North and South, which continued for a good number of years and which Dr Boyd and many of the other consultants present reflected was a very positive and useful learning opportunity. During that time, trainees from the North regularly travelled to Dublin on a fortnightly basis to join the academic teaching with their peers, as a result being exposed to great opportunities for networking and joint learning. Presently there are 29 SpRs in child and adolescent psychiatry training in the Irish College and five SpRs in Northern Ireland. It would be a fantastic opportunity if joint teaching could be re-established to develop training connections and promote comradery amongst this relatively small group of higher trainees across the island of Ireland. This proposition was well received by all present and will be discussed further at the Joint Winter Conference in November.

Invitations were extended by Dr Wilson for the Joint Ulster Paediatric Society /RCPsych in Northern Ireland conference in June and the Annual Scientific Conference in Belfast in September. Lots of interest was evident. An invite was extended by Gerry McCarney to the Joint Winter Conference of RCPsych in Northern Ireland/Irish College in November and it is hoped that a workshop will be arranged for a meeting of the child and adolescent faculties to further discuss issues, including SpR training and the development of an ongoing relationship.



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CAMHS mentorship scheme Northern Ireland

Anonymous

My experience of being mentored

When I was first given the opportunity to speak to someone who had recovered from anorexia, I was thirteen years old. At that time, I was in hospital and totally in the grips of my illness. I was very hesitant and nervous when agreeing to speak with the past patient, as I was so embarrassed about my illness. However, the experience ended up being the best thing for me. The girl I met was such an inspiration to me - she was so beautiful, bubbly, full of life.... it was hard to believe she had ever been where I was. She told me her story and about her journey to recovery. Everything she said resonated with me and I felt that someone truly understood. It was the first time I actually started to believe that I was unwell.

As you can imagine, at this stage, I had very little insight into my illness, so it was so reassuring to see that the girl was a healthy weight, because at that time I thought the nurses were never going to let me stop gaining weight. The experience was unbelievably reassuring for both me and my family, as hearing someone else's story made us believe that things could get better. I really can't put into words how valuable it was for my recovery. It was a real turning point for me, as I finally saw light at the end of the tunnel and had motivation to change.

I'd heard the same kind of advice so many times from my family and from professionals, but it's so different hearing it from someone who has actually been there and been through what you've been through. As soon as I met this girl, I remember saying to my mum and my nurse "I want to do that one day". I wanted to help people in the same way that she had just helped me, and this was a real motivator in my recovery.

I actually got to speak to this girl a couple of times, at different stages in my recovery, which I found very helpful as I had different worries and concerns, which we were able to discuss at different stages i.e. when I became weight restored.

My experience of mentoring

Fast forward a few years and I was at a stage in my recovery where my nurse and I felt that I was able to be a mentor myself. I absolutely love mentoring; I get so excited when the team tells me there's someone who wants to meet me, as the feeling I get, knowing I'm helping people, is indescribable. I've been through exactly what the patients are going through, so I feel like I know exactly the right thing to say and the right things not to say and I know exactly what the patients will be worried about.

I wrote 'My Story' which the nurses often give out to new patients and families coming into the service. This was basically a few pages detailing my journey with the illness and my recovery. Not only was this therapeutic for me to write, but I have received a lot of positive feedback, not only from patients who found that this gave them hope and reassurance, but also from family members who didn't quite understand the illness. They said it gave them an insight into how their loved one was feeling.

Mentoring for me makes me feel like I'm giving back to a team who did so much for me. Of course, sometimes it's hard and it breaks my heart to see people going through what I went through, as I can empathise with them so much. However, recovering from anorexia was the hardest thing I've ever done and hopefully will ever will do, so if I can make the process easier for other people and allow them to see light at the end of the tunnel; that's just the best feeling for me.

Hearing that I've positively impacted someone's recovery or given them the motivation to change is such a privilege and I'm eternally grateful to the team for giving me this platform from which I can share my experience to help others. The mentorship scheme has allowed me to turn an absolutely horrible experience in my life into something positive and meaningful.

Is it a good model?

In my opinion, the mentorship scheme model is excellent and very successful. It's such a simple concept which has such amazing outcomes. Of course, everyone's experiences of mental ill health and recovery will be different but being able to discuss any similar worries or experiences is invaluable to the patient.

Do you think we could extend the scheme to help young people with other diagnoses? e.g. OCD.

Yes, I definitely think that the mentorship scheme could be used to help patients with most diagnoses. The main strength of the model, in my opinion, is allowing the patient to see that things can get better and this is could definitely be replicated for other diagnoses.

Would mentoring be helpful for young people transitioning towards adult services?

Yes, I don't see how a mentorship scheme for YP transitioning couldn't be helpful. During this difficult time, I think patients would really appreciate the opportunity to speak to someone who has been through a similar experience.

Anonymous

Expert by experience

c/o stella.galea@rcpsych.ac.uk

Paediatric Liaison Network Update



Birgit Westphal

Our network is going from strength to strength and we seem to thrive on challenges. We had a big change in our executive group as Elaine Lockhart stepped down as PLN co-chair in February, after three years of intense and very effective joint working on standards for young people in the interface between mental and physical care systems.

Elaine has enabled us to anchor paediatric liaison securely within the Child and Adolescent Psychiatry Faculty and we have since consolidated relationships and productive co-working with many stakeholders – especially the Paediatric Psychology Network (PPN). We thank Elaine for all her amazing work, and we are looking forward to hearing about her new adventures as Clinical Advisor to the Scottish Government.

Following the motto: ‘If you want something done, ask a busy person’, Ginny Davies was proposed as successor to Elaine, and was unanimously elected at our winter meeting. It is fair to say that we have not stopped since.

Since there have been no updates in this newsletter since our winter or our summer meetings, let me feedback that both were marked out by the quality of the speakers who graced both programmes. Our winter meeting at Institute of Child Health (ICH) had superb talks from psychiatrists Professor Elena Garralda (CFS, PICU and inflammation), Matteo Catanzano (early results from the Lucy Booth project at GOSH) and Osman Malik (PANS and PANDAS) and paediatrician Sreena Das (dealing with FII at a very personal level). Our summer meeting at Addenbrookes had more brilliant presentations from psychologists Sara O’Curry (NICU supervision work) and Fergus Gracey (acquired brain injury), ST5 and ST6 Anna Moore and Helen Caisley (ED data from Addenbrookes) and paediatric gastroenterologist Camilla Salvestrini and psychiatrist Sri Velandy (management of MUS). We are hugely grateful to those who help host these events (this year Isobel Heyman at GOSH and Sri Velandy at Addenbrookes) and look forward to next year’s meetings on **31 January 2020 at Institute of Child Health and 26 June 2020 at Birmingham Children’s Hospital**. Save the dates!

We have continued our joint work with our colleagues in the Liaison Faculty and the Paediatric Psychology Network (PPN), as well as with the Royal College of Paediatrics and Child Health (RCPCH).

Liaison Faculty collaborationPosition Statement:

In May 2019, the RCPsych [Position statement on the provision of liaison psychiatry services across the lifespan](#) was published and we describe how liaison psychiatry services can be delivered to meet the needs of patients of all ages.

Diabetes Working Group:

Ongoing: development of a care pathway template for diabetes and mental health in a working group that has been convened by NHS England and Diabetes UK.

Ongoing: update of College report on Diabetes, with contribution from paediatric liaison psychiatry
Imminent following consultation and comments from PLN: Review of NICE guidelines 'Diabetes (type 1 and type 2) in children and young people: diagnosis and management'

RCPCH collaboration

1. We are both members of the Mental Health in Paediatric Care Steering Group (which includes representation from the RCPsych, RCPCH, PPN, Association of Child Psychotherapy and Royal College of Nursing. Watch out for the Position Statement 'Provision of whole child care in hospital'. The current draft is being revised following feedback from all stakeholders and will be published soon.

2. On 16th July, Elaine Lockhart spoke to a group of paediatric colleagues at the RCPCH at a meeting about standards and solutions in paediatric emergency medicine. Elaine conducted a very interesting straw poll of the 47 delegates, a mixture of emergency department (ED) doctors and nurses and general paediatricians:

- i. How many of you came into this specialty to work with mental health presentations? 0%
 - ii. How many of you have had training in children's mental health for more than 1 day? 17%
 - iii. How many of you have had mental health training in your PDP at any stage? 10%
 - iv. How many of you have on-site CAMHS clinicians who see your patients in the ED? 62%
 - v. How many of you have a regular meeting with CAMHS colleagues, more than once/year? 46%
- This is in the context of 30% ED presentations relating to mental health!

3. Ginny continues to work with the RCPCH Facing the Future Emergency Care Standards committee, who are currently auditing paediatric EDs compliance with the mental health standards

RCPsych Psychiatric Liaison Accreditation Network (PLAN) collaboration

[Quality Standards for Children & Young People for Liaison Psychiatry Services](#) are currently being piloted.

Paediatric Psychology Network (PPN) collaboration

Following a coincidental overlap at the Institute of Child Health last February, our two executive teams have continued to work closely together, holding regular telephone conferences during which we jointly brief each other about meetings attended and requests coming into our two networks. This work started back in 2016, so hugely pre-dated the call from our College President, Professor Wendy Burn, to set aside our differences. You may have seen the joint position statement (*Psychiatrists and*

Psychologists pledge to end bitter adversarial dynamic) that was published after she linked up with the Chair of the British Psychological Society *.

The PPN hold a national annual conference, and, just in case you were unaware, you are welcome to attend. This year the conference was held at Addenbrookes on June 6 and 7, and Elaine, Ginny and I went. Elaine and I were delighted to be invited to run a workshop about joint working between psychologists and psychiatrists, which we called 'Together we stand, divided we fall'. It turned out to be a fantastic mutual learning experience and we are hoping to write up the learning points for distribution between our two networks.

We were all impressed by the quality of talks and poster presentations across the two days. The whole event had a wonderfully up-beat and friendly atmosphere and was very well organised. We'd all recommend it as a great place to access really stimulating CPD.

Counsellors Working Within Psychological Medicine
Sally Davis, Beverley Hilsden, Judith Kiley-Morgan, & Jane Whitfield
Psychological Medicine Service for Children, Young People and Families, Addenbrooke's Hospital, Cambridge, UK

Paediatric counsellors at Addenbrooke's work within a multidisciplinary team whose role is to support the emotional and psychological wellbeing of children, young people and families living with chronic and acute health conditions to achieve their optimal quality of life. Counsellors work in both inpatient and outpatient settings, and also support the staff working with these families.

Role of Counsellors

- Work with parents and children with physical health conditions and their families
- Emotional support for parents and families during admissions and after discharge
- Staff support – e.g. de-briefs, staff counsellor, and teaching
- Supervision groups (e.g. nursery nurses)
- Liaising with external agencies – e.g. schools, social care, other medical settings
- Bereavement support:
 - Often facilitate co-ordination of processes that follow after death
 - Bereavement follow up, 1-1; telephone, chapel of rest, registration, emergency assessments (GP, Psychiatry, Crisis team) Memory making, sibling/extended family support.
 - Monthly candlelight service for staff
 - Annual remembering service for families

What we do

Therapeutic relationships built on the core conditions – empathy, congruence and unconditional positive regard

- Counselling individuals & families
- Facilitating peer support groups
- Acute distress response
- Grief, loss, end of life and bereavement work
- Emotional support, coping strategies
- Adjustment to diagnosis and long-term support alongside treatment
- Creative work – e.g. sibling diaries, activity books for young people, scrapbooks for parents

How we work

An integrative approach: our practices are informed by a number of models.

- Trauma
- Mindfulness
- Compassion-focused
- Narrative
- Couples work
- Grief and loss
- Attachment

Within the team, there are practitioners trained in different specific models:

- CBT
- Systemic
- Person/client centred
- Adlerian therapy

MDT working and liaison:

- Liaising with health professionals, external agencies
- Disposing
- MDT working, ward rounds, psycho-socials, consultation
- Bereavement Liaison: with chaplaincy, coroner, mortuary, Registrar's Office
- Supporting psychological thinking/consideration of psychological factors when working with families

Working with Paediatric Liaison Psychiatry:

- Assessment: joint work
- Joint teaching and training on mental health, well-being
- Sessions for staff
- Joint sessions with families and young people

Collaborative working with Clinical Psychologists:

- Joint therapeutic work
- Family work
- Group work
- Teaching, training and presentations
- Triage and referral for cognitive assessments, specialist interventions
- Staff support, supervision and networks

Referral process:

- Referrals from medical staff
- Self-referral from patients and family members
- Referrals from other staff and agencies – e.g. social workers, chaplaincy
- Informally in clinic and on the ward

Clinical areas we work in:

- Genetic Paediatric units
- Diagnosis and Rheumatology
- MCU
- NICU

Fig 1: we were impressed by the work delivered by counsellors at Addenbrookes Hospital

Survey and mapping of Paediatric Liaison Services for NHS-England

Please watch out for our survey email. This is a project being run by the PLN, PPN and PLAN and we need your help with ensuring this mapping exercise accurately captures child and adolescent mental health provision and lack of provision in acute trust / hospital settings.

*Joint statement released by Sarb Bajwa (CEO of BPS) Niall Boyce (Editor of The Lancet) and Wendy Burn (President of the RCPsych) [Researching, practising, and debating mental health care](#)

Birgit Westphal on behalf of Birgit Westphal and Virginia Davies
Co-chairs Paediatric Liaison Network
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Report from Child & Adolescent Psychiatry Specialty Advisory Committee (CAPSAC)



Suyog Dhakras

Curriculum Review

CAPSAC continued to be busy and exciting, with work ongoing on the curriculum review. We had held a Training Programme Director (TPD) conference in association with a CAPSAC meeting in March 2019 and started the work on the initial submission to the GMC COG (Curriculum Oversight Group) of our purpose statement. We have followed this up with meetings in May and July and we are on track to have a draft ready for submission in late September 2019. Once the purpose statement receives approval from COG, we then start the main task on the body of the curriculum. I'd like to thank all those who are working with me on this venture (my CAPSAC colleagues, TPD colleagues and others) for their help, hard work, participation and good humour! I'd especially like to thank the CAPSAC trainee representatives for the invaluable work they've done, not only in representing trainee opinions but also for carrying out an important piece of stakeholder engagement work by conducting a survey of all trainees on the issue of mandatory and selective intended learning outcomes. TPD colleague, Julia Gledhill, also carried out a survey regarding research competencies in the curriculum. It will be interesting to see those results.

I attended the International Congress this year and joined colleagues to not only promote CAP as a specialty and career choice, but also publicise the curriculum review.

CAP Run-through Training Pilot

I really enjoyed welcoming to our run-through pilot induction on 22 July this year's intake of run-through trainees (starting August 2019). All 14 places offered were filled. It was equally lovely to meet trainees who had started in last year's intake, as well as several supervisors, TPDs and mentors. Pauline Whitelaw and Alice Simpson coordinated the day really well (including excellent refreshments – thank you!). I'd also like to thank Helen Bruce and Bernadka Dubicka for joining us in the morning and welcoming the trainees. I was encouraged to see a couple of GP trainees joining the pilot, having decided to join CAP training. I also had a helpful meeting with the National Recruitment Board and we agreed 20 places in the pilot next year (to start August 2021).

We have also started the process of collecting qualitative feedback from the trainees who've finished ST1 in the pilot project.

Other initiatives having implications for training

Bernadka and I attended a meeting at the Royal College of Paediatrics and Child Health (RCPCH) with RCPCH colleagues and Health Education England to look at joint training activities. I have also been involved in providing feedback on certain paediatric mental health training modules for RCPCH trainees; colleagues (Birgit Westphal and Virginia Davies) are already closely involved in that liaison work. Our Faculty is also involved in the ongoing work at the College on the response to the Government's proposals regarding 0-25 services (Long Term Plan).

CAP Essay Prize 2019

The topic this year was: *Deliberate self-harm among children and adolescents carries risk for the young people, for their families and society. Please discuss the causes of these behaviours, the evidence base for treatment and the issues for society*

We had 10 excellent entries and the unanimous winner was Ellen Macpherson. Thanks to Priya Rajyaguru and Priyanka Palimar (CAPSAC Trainee reps) and Chris Bolls in helping me mark the essays and Stella Galea in helping us manage the process. It was heartening to see the interest in child and adolescent psychiatry from these students. ****Read Ellen's winning essay on page 29****

Please get in touch via email. I look forward to hearing back from Faculty members regarding any comments, especially re the curriculum.

Suyog Dhakras

CAPSAC Chair

c/o stella.galea@rcpsych.ac.uk

Trainees' Report



Priyanka Palimar and Priya Rajyaguru

As you have hopefully seen, we've invited trainees to submit a poster to this year's College Child and Adolescent Psychiatry Trainee Conference. The deadline to submit an abstract is **30th August 2019**. Details of how to submit below. The conference is on **Thursday 7th November 2019 at Conference Aston in Birmingham**, so please save the date. A booking link and agenda will be circulated soon. The Midlands venue is just 15 minutes' walk from Birmingham New Street station, so we're hoping to connect specialty trainees from across the nation. Our speakers will enlighten us on technology use and children's mental health, leadership tips for child and adolescent psychiatry trainees, the Tavistock's Gender Identity Service, an alternative child and adolescent psychiatry career and how to use the media to advocate for children's mental health. In addition, Dr Dhakras will be briefing us about the anticipated curriculum changes; he'll also be also seeking your opinions in relation to content. Thanks to those who have already completed various surveys regarding the curriculum. Your responses will aid the discussions at CAPSAC.

So other than organising the conference and helping with the design of the new curriculum, what else have we been doing? So far, we've attended Executive Committee Meetings, CAPSAC meetings, assisted on surveys and are members of the panel which judges the medical student essay prize. If you are interested in becoming the next trainee representatives and are an ST4-6, please raise your interest at the Trainee Conference. However, if you are not able to attend send us your expression of interest in advance. Depending on the number of individuals keen to take on these roles, a vote will or will not take place.

Submitting a poster to the trainee conference

All Child and Adolescent Psychiatry Higher Trainees, Core Trainees and Foundation Trainees are invited to submit a poster of clinical, academic, educational or other relevance to this year's RCPsych National Child and Adolescent Psychiatry Trainee Conference. This year's event is to be held at Conference Aston, in Birmingham on the 7th November 2019.

Please note the deadline to submit an abstract is **30th August 2019**. Abstracts should be no more than 300 words, including the title and subheadings.

Please use the subheadings below to structure your abstract and send your word document as an attachment by email to ppalimar@nhs.net. Include in your email, the main presenting author's name and training grade.

Title
Background
Aims
Methods
Results
Conclusions

We look forward to hearing from you and we look forward to seeing you in November!

Priyanka Palimar and Priya Rajyaguru

c/o stella.galea@rcpsych.ac.uk

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

Adi Sharma, Alan Quirk, Tamsin Ford and Priya Hodgins

We would like to welcome the 60 newly qualified consultants who joined our CAPSS database this summer and hope that you will contribute to our two studies that are currently running.

Study Updates and Impact

The **Early Onset Depression** surveillance study was launched January 2019. Please look out for these yellow e-cards in your inbox. The team have been notified of 77 cases. This is higher than we were expecting and it is good to see that clinicians are engaging in reporting. The response rate is about 50% from the electronic cards. This is the first study to be completely run using e-cards and we would encourage you to keep responding and we are hoping the response rate will rise.

The **Sydenham's Chorea** surveillance study was launched May 2019. Please look out for these yellow e-cards in your inbox. Its paediatric surveillance had previously started, and the team have been notified of 21 cases in the first six months. Please contact Tamsin Newlove-Delgado or Oana Mitrofan (t.newlove-delgado@exeter.ac.uk; o.mitrofan@exeter.ac.uk) for more information about this study.

Impact

A survey using the Child and Adolescent Psychiatric Surveillance System looked at '**Paediatricians' Experiences of working with Child and Adolescent Mental Health Services in Managing Common Childhood Conditions**' and was presented at the 7th Congress of the European Academy of Paediatric Societies (EAPS 2018), Paris, France. Thematic analysis suggested that collaborative working leads to more positive outcomes. Identified barriers to integration were lack of staff and resources and high referral thresholds.

The results of the NIHR funded CATCHuS surveillance study will be published shortly in the BJP and a detailed report to NIHR. <http://medicine.exeter.ac.uk/catchus/> for more information.

CAPSS studies are only as good as your reports and support.

Look out for those “e-cards” when they come. Keep responding as knowing that you DID NOT see a case is as important as knowing that you did.

If you are a consultant child and adolescent psychiatrist who has or will be awarded a CCT in the next six months, please join our database.

Current responders, please send any changes or updates to your email to CAPSS@rcpsych.ac.uk

Adi Sharma, Alan Quirk, Tamsin Ford and Priya Hodgins
On behalf of CAPSS Executive Committee
capss@rcpsych.ac.uk

Young people’s mental health debate Blackpool November 2018

Carla Duncan

Reflections from staff and students at Blackpool Sixth Form College

Blackpool Sixth Form College was pleased to host the first of the Royal College of Psychiatry’s Young People’s Debate on Mental Health to be held in Lancashire. In a joint venture with Blackpool Teaching Hospitals, Blackpool CAMHS and Blackpool Council, members of the Royal College joined with students to debate the motion ‘This house believes that social media is bad for mental health’. This was a very emotive topic that drew strong opinions from the debaters and also the audience, which was made up from local professionals and organisations, as well as students from the College and local high schools.

Upper sixth students Ellie Fox and Courtney Wood had spent time researching their arguments and compiling their presentations, with support from Dr Mindy Reeves, from the Royal College, and Lucy Fennuci from Blackpool Teaching Hospitals Trust.

When the final vote was cast, 61% of the audience agreed that social media was bad for mental health, meaning Ellie and Mindy, arguing in favour of the motion, were the clear winners. However, Courtney and Lucy’s compelling arguments, swung the voting and increased their 'no' share of the vote by nearly 17%.

Ellie said of her experience, “This debate was a great opportunity which I am glad to have taken part in. I was particularly interested as it was a great opportunity to work alongside the Royal College of Psychiatrists, who I really enjoyed working with. It was very interesting to exchange ideas with them and listen to professional opinions about the subject. It was also interesting to hear a variety of opinions within the panel and the people in the audience; it was certainly eye-opening.”

Dr Bernadka Dubicka chaired the debate excellently and had a wonderfully calm manner. She used her closing comments to raise awareness of the fact that, whilst social media may often be blamed in the media for negatively impacting mental health, there are many greater issues affecting the young people in our area, including poverty and disadvantage. Votes of thanks were given at the end by Dr Vasu Balaguru (Royal College of Psychiatrists, Blackpool Teaching Hospitals Trust), who had been instrumental in organising the event.

Maja Kazmierczak, a student who attended the debate, reflected on its resonance for her:

“Before the debate, I myself was a firm believer that social media was the sole perpetrator in the increasing cases of mental health-related issues in younger people. Now, however, I’m made to think twice. A point which was most prominent for me, one which was made by a member of the audience, was that ‘social media only reveals these mental health issues, it does not create them’.

I feel this debate was the first pebble to fall in the movement to help those suffering silently with mental health; the first pebble, which will in time cause an avalanche. As a young person, it was the best step which could’ve been taken by both professionals as well as the students witnessing this suffering in their friends, family or even themselves.”

Prior to the debate, local organisations hosted stands in the College’s foyer to raise awareness of the support and opportunities available for young people in our local area. Blackpool Young Carers, Headstart, Entwined Minds and UR Potential engaged with student and visitors to discuss the challenges young people face and the help available. Since the debate, Headstart have been back in college to talk to our students and Lucy Fennuciu has also met with our Student Council, to take forward ideas that the debate raised. They are planning to roll out their new ‘Learn to Live’ campaign in the near future.

Overall, it was wonderful to listen and to be part of the event and our students and visitors got a lot out of it. Mental health is an issue that affects us all in different ways and it was a great opportunity for our students to listen, to talk and to get involved, and its impact is continuing to be felt.

**Carla Duncan,
Staff, Additional Support
The Blackpool Sixth Form College**

Letters to the editor

A response to Peter's Hindley's letter: Why is frozen watchfulness a psychiatric disorder? The risks and benefits of psychiatric labels (Spring newsletter)

A colleague and friend recently pointed out to me the etymology of 'diagnosis': it comes from the ancient Greek and is in two parts 'dia' - discrimination or categorisation, and 'gnosis' - understanding. This is one of the core skills that we learn as doctors. From the start of medical school, we are taught to recognise patterns of symptoms in a way that can help us make inferences about the likely causes. We practise, early on at medical school, to discriminate heart failure from asthma in a breathless adult, by grouping the breathlessness along with swollen ankles rather than wheeze. Much later, we might learn to discriminate Autism from Reactive Attachment Disorder by grouping social relationship problems along with repetitive and stereotyped behaviours, rather than with failure to seek comfort.

Like Peter Hindley, I too was dismayed by the "worst excesses" of US insurance-driven psychiatry at our September CAMHS Faculty conference, but it was the divisions and sub-divisions of child and adolescent depression in Gaye Carlson's otherwise wonderful keynote address that woke me up to this. I wouldn't target Charley Zeanah with this accusation because, in my experience he is a thoughtful and probing clinician who uses diagnosis judiciously and only when useful.

I suspect the real reason Peter was shocked was at the use of diagnosis for infants and tiny children. I would counter that these tiny humans are as deserving of our discriminating understanding as anyone else.

Peter focuses on 'frozen watchfulness' and I would agree that one shouldn't call this a diagnosis because, as he rightly says, this is a reaction to abuse and therefore is not a problem inherent in the child. But I don't have a problem with using the diagnostic term Reactive Attachment Disorder (RAD), which can include the symptom of 'frozen watchfulness', even for a little baby. To fulfil criteria for RAD, the child would also have to display symptoms of failure to seek comfort and emotional withdrawal in various situations, as well as problems with emotional regulation. Our research, and Charley Zeanah's, has shown that children with RAD usually also have other problems such as ADHD. Like any other diagnosis, one wouldn't use the diagnostic term RAD unless the child carried these problems from place to place – home, school and friendships – and was impaired by them.

I had a 15 year old boy referred to me a couple of years ago with 'query autism'. He had no repetitive or stereotyped behaviours or sensory problems, but he had very significant difficulties with social relationships. A bit of probing with the boy and his foster carer revealed that he had been placed with her at the age of 4 ½ as an 'emergency' and was still there more than a decade later. He had never sought or accepted comfort from her but, because she was used to fostering babies and toddlers with significant learning and physical difficulties rather than grossly neglected pre-schoolers, it didn't occur to her to go beyond her ordinarily sensitive instincts and use what Mary Dozier would call 'gentle challenge'. Gentle challenge is the approach recommended for children with problems signalling their

needs, i.e. for carers to 'warm up' the child by being ever so slightly intrusive and offer the child what s/he needs rather than what s/he is asking for. This boy therefore utterly failed to use his attachment system to engage his foster carer to help him with his development. At 15, he had severe difficulties with regulating his emotions and with conducting all of his relationships, including with teachers and friends. His RAD could probably have been treated successfully with one to three sessions of Video Interaction Guidance or some similar relationship-focussed intervention if it had been recognised in the pre-school period. He could have had a whole world of supported learning and development opened for him.

In my view, 'frozen watchfulness' or 'failure to seek comfort' is one of our most important psychiatric symptoms because it is a) very hard to spot, b) is fantastically treatable if recognised early and c) seems to have appalling developmental consequences if it is missed and unaddressed. Often, it doesn't reach psychiatric attention because foster or adoptive parents realise that they need to go beyond their usual sensitive caregiving and 'warm up' the child – or they may receive help with this from a tuned-in health visitor. This is no different from the way suicidal thoughts in an adolescent often don't reach psychiatric attention because a friend, parent or teacher realises something is wrong and helps address the underlying problem. If suicidality has been missed, has become entrenched, or is coupled with severe depression or anxiety, then a psychiatrist might be required. If failure to seek comfort has been missed, become entrenched, or is coupled with other problems (such as autism or ADHD), then a psychiatrist might be required to discriminate, understand and recommend the right treatments/management strategies.

It is hard enough to acknowledge the extreme distress of our suicidal teenagers. We would rather not imagine that they really can feel this terrible. This is even more true of our babies and toddlers: you will struggle to find a photograph on Google images in which a baby is not smiling. Peter Hindley reminds us that we must listen to and understand the experiences of children and young people, including recognising behaviours in the very young that reflect their experiences. 'Frozen watchfulness/failure to seek comfort' is a developmental emergency that means the baby/young child is not using their attachment system. It is hard to recognise and is often coupled with other neurodevelopmental problems. As psychiatrists, we need to engage with this important symptom.

Helen Minnis
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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

Contact the Faculty Exec and any of the contributors c/o

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Prof Alka Ahuja	Financial Officer
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Mrs Toni Wakefield	Carer representative
Dr Susan Walker	Elected member, Mental Health Law
Dr Birgit Westphal	Paediatric Liaison
Dr Dave Williams	Welsh Government
Dr Richard Wilson	Chair of Faculty in Northern Ireland

Prize winning essay

Ellen Macpherson

Read the winner of the 2019 Medical Student Essay Prize. Ellen Macpherson is a student at University College, London

Deliberate self-harm among children and adolescents carries risk for the young people, for their families and society. Please discuss the causes of these behaviours, the evidence base for treatment and the issues for society.

Introduction

Deliberate self-harm [DSH] is often reported as being on the rise among young people and, more worryingly, the age of onset of this behaviour has been found to be getting younger.ⁱ DSH refers to acts of self-injury, such as cutting, burning or hitting, and acts of self-poisoning, typically overdosing on medication. Understanding DSH is made more difficult by a lack of cohesiveness in the literature. Many maintain that there is a dichotomy between acts of suicide and non-suicidal self-injury, whereas others posit that self-harm and suicide exist along a continuum.ⁱⁱ In conjunction with this, there are many different terms for DSH peppering the scientific landscape including nonsuicidal self-injury [NNSI], parasuicide, self-mutilation, self-mutilative behaviour [SMB], self-harm and nonsuicidal self-harm. All of these terms have slightly differing nuances and connotations which makes synthesising their meanings into one universally applicable term near impossible. In this essay, the term DSH will be used throughout to refer to both suicidal and non-suicidal self-injurious acts except when referring to a study or article in which the authors have employed a different term, in order to maintain a sense of clarity.

Traditionally, DSH has been regarded as a facet of other psychological disorders and not as a behaviour meriting treatment in its own right. However, this is beginning to shift and in the DSM-5, NNSI and 'suicidal behaviour disorder' are included as 'conditions for further study'.ⁱⁱⁱ Prior to this, in the DSM-IV, self-harm was simply considered to be a symptom of borderline personality disorder [BPD], major depression or stereotypic disorder.^{iv} Not every instance of DSH occurs within the context of a psychiatric illness, however. Prevalence for DSH, while difficult to gauge, has been placed as high as 25.7% in women aged 16 to 24 and suicide is often cited as being the leading cause of death in men under 50.^v Regardless of the specifics of these statistics, which are ever in flux, it is indisputable that every lethal act of self harm represents a tragically preventable cause of mortality. Self-harm, even if it is not explicitly suicidal in intent, predicts future suicide attempts and future completed suicides. In better understanding DSH, there is the potential for developing improved treatments and prevention strategies and, ultimately, lowering the rates of morbidity and mortality related to it.

In this essay, I will first discuss the causes of self-harm, outlining the difficulties implicit in demarcating simple associations from contributing factors, describe some of these factors in detail and outline a model which brings them all together. I will then explore the different treatments available for adolescents who engage in DSH and the overlap that exists with borderline personality disorder treatments. A case study of a young female patient

is used to aspects of these discussions. Finally, I will discuss the ripple effect which DSH can have on the individual, their family, their peers and school, and society at large.

Section 1 - Causes

When commencing a discussion of causality, it is important to reiterate that DSH is regarded as a behaviour and not a condition in and of itself. In modern western medical philosophy, a reductionist paradigm is often employed that posits that x causes y,^{vi} and while effective at explaining conditions like tuberculosis and lung cancer, this paradigm is often less satisfactory at explaining psychiatric phenomena which are usually multi-factorial. In the case of DSH, the behaviour may comprise an aspect of a psychiatric condition such as borderline personality disorder [BPD] or major depressive disorder, in which case appropriate management of the condition may reduce the DSH behaviours, or it may occur independently of a psychiatric diagnosis.^{vii} Furthermore, the usual trope of 'genetics plus environment', while undoubtedly true, is too vague to be useful in terms of guiding treatments and leading to interventions. Perhaps, then, the best approach for understanding DSH is to identify these common factors and to unify them within the framework of an overarching model.

So what are these contributing factors? The easiest way to conceptualise them is to divide them up into intrinsic factors and extrinsic factors. Intrinsic factors include personality and character traits, psychological factors, and within that any potential psychiatric diagnoses. Extrinsic factors encompasses social and cultural factors. The main intrinsic factors identified in the literature include BPD, depression, hopelessness, premeditation, impulsivity, deficits in problem solving, implicit cognition about self-injury, emotional dysregulation and difficulties in processing emotion.^{xix} Extrinsic factors includes aspects such as gender, with females being more likely to self-harm than males, onset of puberty, socioeconomic status, school experience, peer group, home environment and family dynamics, a history of trauma or abuse, social media use and cyberbullying specifically, substance misuse and relationship difficulties.^{xiv} Neither of these lists is exhaustive, but together they give a sense of the breadth of the factors that contribute to DSH and the implicit difficulties in targeting specific factors as means of treating or preventing DSH.

Many different models have been proposed that attempt to amalgamate these factors into a coherent framework. As outlined in Messer and Fremouw's review, many of these models have explanations in common, largely focusing on affect regulation.^{xviii} The most rigorously studied of these is Nock and Prinstein's four function model, which employs 'a functional approach [which] classifies and treats behaviours according to the functional processes that produce and maintain them'.^{xix} Nock and Prinstein divide these functions by whether they are internally reinforced, i.e. automatic, or reinforced by interpersonal relationships, i.e. social. Automatic-negative refers to using DSH to minimise negative affective states, whereas automatic-positive is where DSH serves to induce a desirable physiological state. Social-negative reinforcement refers to using DSH to avoid interpersonal demands, whereas social-positive refers to using DSH to gain attention from others. More than one function may contribute to someone's pattern of DSH.

Though the exact function of DSH tends to vary by demographic correlates, in studies where Nock and Prinstein's four-function model has been applied to self-harming populations, the most widely cited functions tend to be automatic-negative and social-positive.^{19xx} This corresponds to DSH being used to diminish internal distress and to communicate that distress to others. Whilst not a perfect means of understanding DSH, particularly because Nock and Prinstein refer exclusively to non-suicidal self-injury and not to DSH attempts with suicidal intent, this model still goes some way in explaining how different causal factors can generate the same internal motivation to engage in DSH. It also engenders a treatment approach whereby substitute behaviours can be introduced that serve the same function as DSH did for that individual.

Section 2 - Treatments

In terms of treatment for DSH in adolescents, there is a relative paucity of evidence and specific studies. Many of the treatments which have shown promise in this patient group were originally developed for adults with BPD. Two such treatments are dialectical behaviour therapy [DBT] and mentalisation based therapy [MBT]. These are both unique in the literature in that randomised control trials have been conducted to look specifically at their effects in adolescents who self-harm and, from that, have been shown to be effective.

DBT was first developed in 1991 by Linehan et al in order to treat BPD patients with chronic suicidal behaviour.^{xxi} It is a 'multimodal, principle-based treatment that conceptualises emotional regulation based on the biosocial theory'.^{xxii} The biosocial theory states that personality disorders are a result of biologically determined emotional vulnerability and particular environmental stressors, such as invalidating parents.^{xxiii} Consequently, DBT is focused on teaching the individual skills to cope with overwhelming affective states including mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation, in both an individualised and group setting.^{xxiv} A modified version of dialectical behaviour therapy for adolescents [DBT-A] was developed in 1997 by Miller et al. Some of the modifications included reducing length of treatment, adding family therapy sessions and including family members in the skills training sessions.^{xxvxxvi} Two RCTs were conducted looking at the effectiveness of DBT-A in self-harming adolescent populations, one in the US and one in Norway. Mehlum et al looked at DBT-A versus 'enhanced usual care' over a 19 week period in 77 Scandinavian adolescents aged from 12 to 18 and found that there were fewer episodes of self-harm and less suicidal ideation in the DBT-A cohort.^{xxvii} Limitations of the study included a small mainly female sample size, a non-manualised control treatment and only short-term follow up. A similar study was conducted over 4 sites in the US between January 2012 and August 2014. 173 adolescents, aged between 12 and 18, were treated using either DBT-A or a manualised control treatment over a period of 6 months. Assessments were carried out at 3, 6, 9 and 12 months and 'significant advantages were found for DBT on all primary outcomes after treatment'.^{xxviii} The sample size was greater than in the Norwegian study, and the follow up was longer, but limitations persisted and included a majority female sample and the fact that the therapists delivering DBT-A were highly trained and monitored. Whether these results could be emulated with more lax standards of DBT, as might be found in routine practice, is uncertain.

At the same time as DBT was being developed, Peter Fonagy introduced the idea of mentalising in his 1991 article 'Thinking about Thinking'.^{xxix} Conceptualised as 'the process by which we interpret the actions of ourselves and others in terms of underlying intentional states such as personal desires, needs, feelings, beliefs and reasons',^{xxx} the central tenet of MBT is holding the other person's mind in mind. Like DBT, this was originally developed for suicidal adults with BPD and so most of the studies look at the effects of MBT in this population.^{xxxi} Techniques include enhancing mentalising, understanding emotional states and how these are represented in others and working with current mental states.^{xxxii} Only one study has looked at MBT specifically in adolescents who self-harm. Other studies have looked at adolescents with borderline traits who engage in self-harm and suicidal behaviours and have found MBT-A to be helpful in these patient groups.^{xxxivxxxv} The RCT carried out in 2012 by Rossouw and Fonagy looked at self-harming adolescents, 85% of whom were female, in an outpatient setting.^{xxxvi} They found MBT-A to be superior to treatment as usual [TAU] at reducing DSH and depression. Limitations of the study included a small sample size that was majority female and a non-manualised control treatment. This study suggests that, as in adults with BPD, MBT may be helpful in adolescents who engage in DSH, but taking these results in isolation is insufficient evidence for recommending MBT. Replication with a wider sample is needed.

Group therapy was also investigated as a potential treatment for adolescents who engage in DSH. A study published in 2001 demonstrated that it held promise in the treatment of adolescents who engage in repeated self-harm.^{xxxvii} However, attempts to replicate the findings of these studies have failed to show any benefit to group therapy.^{xxxviii} The trajectory of this treatment in studies demonstrates the need for more rigorous investigation of DBT-A and MBT-A as the validity of the results from the RCTs outlined above can only be improved by replication of result findings. Consistently, throughout these RCTs, there was a marked absence of adolescent males from population samples. This severely limits the results of these studies from being applied to quite a significant proportion of adolescents who engage in DSH. Going forward, more RCTs need to be studied with larger patient samples that include a more equal distribution of genders, longer follow up periods and, as with the US study looking at DBT, with a manualised control treatment for more standardised comparison.

Section 3 - Case Study 'Jenna'

Note: names and personal details have been altered.

Having done my psychiatry placement on a general adult men's ward and an adult eating disorder ward, I had limited experience with adolescents with mental health issues. However, many of the patients which I encountered, particularly some of the young female patients on the ED ward, reported engaging in self-harming

behaviours that started in their adolescence. I contacted the child and adolescent mental health service in the hospital in which I had done my placement and managed to organise a meeting with a young patient who had previously engaged in DSH. She was very pleasant and open about her experiences, expressing a desire to increase awareness around DSH and mental health issues in general.

Jenna's experience:

Jenna is a 17 year old female who has recently been discharged from CAMHS. She started self harming at the age of fourteen. The first instance of DSH occurred while she was in the shower and was experiencing what she described as 'an angry and frustrated state of mind'. After that, she began to associate the shower with self-harming and would often engage in self-harm at the end of the day while washing. Initially she described cutting with razors as her main form of self-harm. This progressed to include forms such as burning herself, for example with hair straighteners or a curling iron, and hitting herself hard enough to create bruises. She described a sense of mounting tension throughout the day, worsened by hearing as many as twenty different voices that urged her to self-harm and difficulty concentrating on anything beyond the immediate urge. She was emphatic that there was a 'feeling of release' when engaging in the act, but that it was very much short-lived. Afterwards, she described feelings of regret and guilt.

Jenna engaged in self-harm in secret for a year until her friends urged her to go and see the school counsellor. She did so, albeit reluctantly, and was then referred by the school counsellor to CAMHS after a month. She said that the experience was 'horrible' and that she felt a sense of failure at having to be referred, especially as it meant that her mother, with whom she has a very close relationship, would need to get involved. Until then, she had kept her self-harming behaviour secret from her out of a desire to save her mother from any emotional distress. An urgent referral was made because at this point Jenna was experiencing increased suicidal ideation and had already attempted suicide twice. These attempts consisted of cutting her wrists and hitting her head and, though not severe enough to warrant a trip to A&E, nevertheless marked a significant deterioration in her mental wellbeing. She denied taking any overdoses or self-poisoning.

In terms of family history, there is a significant history of depression on Jenna's paternal side and she attributes a poor relationship with her father to the fact that he suffered from depression throughout most of her childhood. Her parents are still married and she has an older sister at university and an older half-sister with whom she has little contact. She has an aunt on her mother's side who has OCD. Her sister suffers from anxiety and OCD but has never engaged in DSH herself or had contact with CAMHS.

Treatment wise, Jenna was put on 20mg of fluoxetine 6 months into her time with CAMHS. She is still on fluoxetine now. She had received a diagnosis of anxiety and depression. Jenna also received talking therapy which helped her work through issues such as her self-esteem and desire 'not to be herself', with elements of CBT incorporated into this. At first she considered recovery to be 'a huge task', but her willingness to get better changed as she began to see it as a possibility. Her mother was accepting of her mental health issues and their relationship is even closer now than it was before. When Jenna was still engaging in self-harm, her mother would remove the means of doing it, for example taking away her razors, but Jenna says that she would then find another way to self-harm. At one point, she used food restriction punitively, describing it as giving her 'a sense of control' which self-harming had brought her previously.

In terms of acts of DSH, Jenna has not engaged in it for the last two months and the DSH which she engaged in, which was in the form of hitting herself, she described as being less intense. She considers cutting to be her most severe form of DSH. One of these more recent acts of DSH was associated with drinking alcohol, when she repeatedly hit her head on a toilet seat. However, Jenna only drinks socially and does not consider alcohol to have an effect on her mood. Jenna is clear that changes in her DSH behaviour came about when she addressed the aspect of low mood by going on medication. She said that after starting fluoxetine, the urges would come in waves and she would engage in DSH more and more infrequently with greater periods of time in between. In this time, she sat her school exams but did not find academics to be a stressor and actually found studying to be something of a distraction. She did have difficulties with her peer group at school as they were uncomfortable with her being unwell. Now Jenna no longer considers herself to be depressed. She uses many different tools and behaviours to distract from urges to engage in DSH, including talking to her mother and watching her favourite TV show, but finds that it is difficult to get the impetus to seek such distractions when feeling overwhelmed. She also has found an app to be helpful which uses self-soothing techniques and mindfulness

which she says she would have liked to have known about sooner. Currently, Jenna is studying at college and doing very well.

Salient points from the case study:

There are several aspects of Jenna's experience which are common to many adolescents who engage in self-harm. Perhaps most prominently is her description of DSH as serving as a form of short term release from negative affective states. This fits with Nock and Prinstein's automatic-negative function of DSH. Further to this, there was several complex interacting factors which contributed to her underlying negative affective states.

In terms of intrinsic factors, there was an extensive family history of psychiatric illness on both the maternal and paternal side. There was also a personal history of anxiety and depression, which Jenna experienced as severe mood swings, an underlying diffuse sense of tension and highly distressing auditory hallucinations. She also suffered from low self-esteem including concerns over her weight. There was also an element of hopelessness, evidenced by her initial unwillingness to get better. Interestingly, despite the considerable overlap between BPD and DSH as outlined in the literature, there was a marked absence of BPD features in Jenna's history.

In terms of extrinsic factors, the most obvious ones are her gender and her age. Young adolescent females are the most highly represented in the literature surrounding DSH. In Jenna's case, there were also complex family dynamics at play as she had a very close relationship with her mother but a more strained relationship with her father, and also a half-sister with whom she had little interaction. There were also difficulties with her peer group at school, although she identified this as being an effect of her mental ill health and not a cause of it, which highlights the implicit difficulties in disentangling causal and consequential associations in a psychiatric history. There was no history of trauma or abuse or of substance misuse.

Jenna's forms of self-harm took the place of physically violent actions towards herself, including hitting, burning and cutting, as well as severe food restriction, but excluded any self-poisoning. When she experienced suicidal ideation, her attempts took the form of escalation of her pre-existing behaviours. This fits more within the framework of DSH existing as a continuum of suicidality, as opposed to there being such a marked dichotomy between non-suicidal self-injury and self-harm with suicidal intent.

In terms of Jenna's treatment, she attributes much of her emotional regulation and consequent de-escalation of DSH behaviours to her commencing fluoxetine treatment. She did not receive either DBT or MBT therapy specifically. However, I found her comment about the app that taught mindfulness and self-soothing techniques, that she wished she had found it sooner, to be interesting as both DBT and MBT share elements of mindfulness and self-soothing. One of the issues with DBT and MBT identified in the literature has been the difficulties in rolling it out. Perhaps such an app containing some of the basic shared elements of these therapies could serve as a helpful adjunct to whatever therapy the young person is receiving if MBT or DBT is unavailable to them?

Jenna's approach to maintaining her mental health as an active and dynamic process requiring multiple modalities of treatment has no doubt contributed to her overall improved well-being. If nothing else, Jenna's particular case demonstrates that, irrespective of how severe and entrenched these behaviours are, with the right support there is always the potential to get better and attain a higher quality of life.

Section 4 - The Impact of DSH

Paradoxically, for such an intensely personal action, DSH has significant effects beyond the one person at that specific moment in time. There is the impact on the individual's future self, their family, their peers and their school environment and, though difficult to quantify, a cost to society at large. These effects do not necessarily exist as discrete phenomena. Indeed, it is easier to understand the impact of DSH if thought of as a ripple effect outwards.

In terms of the individuals themselves, it is not surprising that DSH is a marker for greater psychopathology and predicts greater psychological difficulties and social difficulties later on in life. These clinical and social outcomes can range from poorer educational and occupational outcomes to increased rates of substance misuse to higher levels of anxiety and depression in adulthood.^{x1} A study that looked at adolescents who had poisoned themselves

found that these individuals were more likely to leave school without qualifications and become parents at an earlier age.^{xli} They also were more likely to have eating and anxiety disorders. Most disconcertingly, it is often reiterated in the literature that adolescent self-harm and suicide attempts predict future suicide attempts and completed suicides.^{xliixliixliiv}

A number of qualitative studies have been conducted looking at the impact of DSH on families, mainly through interviews with the parents of children who self-harm.^{xlvixlvixlvii} Upon discovering that their child has been engaging in DSH, there are often immediate feelings of shock, anger and disbelief. Later, these feelings transmute into stress, anxiety, depression, guilt and social isolation. The response of siblings ranges from anger and resentment to overprotectiveness of their sibling. Often, parents reported that the sibling would feel that they could no longer engage in typical sibling exchanges with the self-harming child for fear that they would exacerbate the problem. The DSH also had the potential to place a financial burden on the family when the parents took time off work to look after the child or pay for private treatment in some cases. These studies have also reported on parents feeling ill-prepared to deal with their self-harming child and the tendency to ruminate on past events with the hope of discovering a 'cause' for the behaviour. At the extreme end of DSH, studies have looked at the impact of suicide attempts and completed suicides on a family.^{xlviiiixlix} Not surprisingly, there are increased rates of anxiety and depression amongst parents who have lost a child to suicide and increased rates of hospitalisation due to psychological morbidity amongst parents who have lost a child to suicide compared with parents whose offspring's death was related to other causes. These differences are not accounted for by premorbid psychiatric problems.

In term of the impact of DSH on schools and peers, there is more of a focus on the impact of suicide attempts and completed suicides than there is on the impact of an individual self-injuring. It is difficult to gauge how DSH impacts schools specifically but a study looking into the response of teachers to NSSI found that most of them would be willing to help a child who engaged in it, but that they knew very little about it and, more specifically, knew very little about how to deal with it.ⁱ In contrast, there have been numerous studies looking at the effect of suicide on peers. Amongst those that directly witness a suicide, there are increased rates of anxiety disorders and PTSD symptomatology.ⁱⁱ Studies in South Africa, Australia and Hong Kong found that amongst the friends and acquaintances of an individual who had either attempted or completed suicide, there was greater levels of psychological morbidity, including feelings of guilt and suicidal behaviours, and more risky alcohol and drug use beyond what constitutes normal adolescent experimentation.^{liiiiiiiv}

The actual economic cost to society of DSH is difficult to quantify and depends on which country and which social and healthcare infrastructure is being looked at. A retrospective analysis of a hospital in Oxford found that the mean cost of an episode of self-harm was £809 and related to such factors as admission to hospital, the length of inpatient stay, treatment in ICU and psychosocial assessment.^{lv} They found self-injury and self-poisoning combined incurred the highest costs compared with either self-injury or self-poisoning alone. Other studies have looked at the longterm costs of a DSH patient. Another study in Oxford which followed up 150 patients who had presented with self-poisoning for 7 years found that in the year following the act of self-harm, the greatest proportion of expenditure was related to inpatient psychiatric care.^{lvi} Patients with 5 or more acts of self-harm and co-morbid personality disorders had the highest resource costs. However, what neither of these studies addresses is that most of the longterm costs of a patient with psychiatric morbidity relates to social care and losses from lack of employment. While productivity losses are difficult to quantify, a study that looked at another cohort of patients that had deliberately poisoned themselves in adolescence found that the greatest costs were related to increased use of service-provided accommodation, greater educational and health-care needs, more criminal justice costs and claiming more social security benefits.^{lvii} The deliberate self-poisoning group averaged a cost of £1500 per year on average versus £65 per year in the control group. These costs were mainly driven by use of voluntary and social sector accommodation.

Overall, it is clear that DSH has significant effects on the individuals within the immediate sphere of the self-harming individual. The greater level of psychological morbidity is not restricted to the self-harming individual alone. Further to this, the economic costs incurred, which in most cases are still underestimated, are significant. Taken together, this highlights the need for effective prevention and treatment strategies.

Conclusion

To sum up, DSH as a psychiatric phenomenon is multi-factorial in origin. A helpful approach to understanding these factors comprises placing them within a schema such as Nock and Prinstein's four function model. As already stated, such models can only be useful if they then guide treatment. In the case of MBT-A and DBT-A, their effectiveness appears to stem from teaching the individual strategies that serve as substitutes for the autonomic-negative and social-positive functions which DSH served. While these have shown promise, more RCTs need to be carried out with longer follow-ups and wider population samples. Longer follow-ups are needed because the impact of DSH is far reaching and extends far beyond the period of time in which the behaviour is carried out. Despite what's already been done, there is still a lot of work that needs to be done with regards to understanding and treating DSH. A greater understanding of the motivation that drives individuals to inflict injury on themselves can only improve current prevention and intervention strategies. Not only is it imperative that high calibre treatments are developed, but it is also important that these are rolled out in a way that ensures they reach the individuals who need them. Too often, those who engage in self-harm are dismissed as attention-seeking and problematic individuals, even by healthcare professionals.

In the case of Jenna, her DSH was a manifestation of her underlying psychiatric morbidity and when that was addressed properly, with talking therapy and an SSRI, her DSH reduced in frequency and intensity. For her, one of the key aspects of her experience was the reaction which she got from other people when they found out. Oftentimes, she felt that others were angry or disgusted with her, or she felt patronised. It was this which drove her need for secrecy and led to her suffering for a year before seeking treatment. The best kind of reaction, Jenna explained, was that of her nurse at CAMHS who validated but did not condone the behaviour. As outlined, there are many aspects of Jenna's case which are typical, but there is one crucial difference between her and many others who engage in DSH. She received treatment where many don't. The positive outcome of Jenna's case hopefully will inspire a sense of optimism in both those who deal with cases of DSH in a professional capacity and those whose lives have been detrimentally affected by the behaviour. No matter how entrenched and debilitating the behaviour, it should be borne in mind that with time and proper care there is always the potential to get better.

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