The development of rights in children can best be described as a plastic process – on one side there is a societal duty to protect and on the other a duty to allow for autonomy.

This tension is ably reflected in the civil law related to the young person, which is in most cases commensurate with the scientific understanding of the developing brain. Criminal law takes a different view and this article will focus on some of the challenges endemic in the current criminal justice system as it relates to young people.

In terms of the developing brain, neuroimaging studies have helped us to understand the areas involved in mental constructs such as empathy, working memory, consequential thinking, reasoning and judgement, planning, and inhibition of behaviour. Physical brain development continues before and after puberty, into the early twenties (Blakemore, 2006; Sowell 2001). Executive functioning, as part of this development, increases over the course of adolescence (Anderson, 2001) and this has been linked with prefrontal cortex development (Blakemore, 2006) in tandem with an emerging ability to engage in consequential thinking (Steinberg, 2009).

As commented on by the Royal Society in 2011, this area of the brain is the slowest to develop (Gogaty 2004) in contrast with the amygdala (reward and emotion-processing), the imbalance of which is thought to account for increased arousal and risk-taking behaviour in adolescence. Adolescence represents a phase of increased impulsivity, sensation-seeking and risk-taking behaviour (van Leijenhorst 2010; Baird 2005; Steinberg 2007), a developing ability to empathise (Strayer 1993) and a heightened vulnerability to peer influence (Steinberg 2007), all of which have an impact on decision-making.

Civil legislation manages these emerging competencies by defining a spectrum of development – this is reflected in the thinking behind the Gillick case – Gillick competency has no lower age limit, but instead reflects that some young people may have aptitudes which allow them autonomy, whilst some may not, irrespective of chronological age. This position is similarly encapsulated in the Mental Capacity Act which, for 16 and 17 year olds, describes a position in which the young person may be ‘overwhelmed by the implications of the decision’ and thus may lack capacity for reasons outwith the definition in Section 2 of that Act (namely ‘an impairment of or a disturbance in the functioning of the mind or brain’).
Criminal law related to children has different aims than civil law, but must still give due consideration to the welfare of the child. Young people are deemed to be criminally responsible from the age of 10 in England, Wales and Northern Ireland (the Republic of Ireland exercises a minimum age of 10 for more serious crimes, but 12 for less serious ones, and Scotland exercises a minimum age of prosecution of 12, though technically their minimum age of criminal responsibility remains at age eight). Whilst a protection for children aged 10-14 used to be in a form of doli incapax, the notion that a child cannot have formed a guilty mind if they were not aware that what they did was seriously wrong, this was removed as a protection by the Crime and Disorder Act 1998. This put the United Kingdom in a relatively small group of countries that maintains such a young age (this group also includes various parts of Africa, Singapore, Indonesia and Papua New Guinea). The average age across Europe is 14, with some countries holding an age of 18.

The aforementioned scientific position in terms of brain development raises serious questions as to how we regard mens rea (the ability to have a guilty mind) in children aged 10 and above. It is also worth delineating that young offenders may be further disadvantaged as they may have a different brain structure compared to young non-offenders – research demonstrates differences in brain grey matter volumes in the brains of children with conduct disorder versus those without. Maltreatment in childhood, common in offending groups, is associated with changes in the hypothalamic-pituitary-adrenal axis (which can be over- or under-responsive as a result); overactivity can result in an increase in impulsive aggression whilst underactivity can result in a lack of empathy, non-responsiveness to punishment, and increased instrumental aggression (Kiehl 2001)

The second element worthy of consideration is effective participation in legal processes. It is noteworthy that the European Court examination of the Thompson and Venable case took the view that neither young person was able to effectively participate in their trial and a violation of Article 6 of the European Convention on Human Rights (the right to a fair trial) was found. The factors already highlighted as potentially impairing the capacity to form criminal intent are also likely to impair the ability to effectively participate in the trial process, though for different reasons.

The MacArthur Adjudicative Competence Study examined 927 youths and 446 adults in America, and found that trial competence related abilities improve with age – 11-13 year olds show less understanding, less reasoning and less recognition than 14-15 year olds, who in turn performed significantly more poorly than 16-17 year olds (who functioned as well as adults). Low IQ scores were particularly associated with deficits. Young people were more likely to waive their rights than adults, more likely to accept plea agreements (even 16 and 17 year olds) and were more likely to make choices in compliance with authority figures. Risk perception and future orientation deficits were found, and young people often did not understand the right to remain silent, and would see rights as conditional. Redlich (2003) similarly found that young people are more likely to falsely confess.

What we are left with as clinicians is an uncomfortable disparity between the civil means of dealing with young people, and the criminal means. So what is the solution? One proposed measure came via the Law Commission, which consulted widely and produced a robust discussion paper in 2013 which discussed a possible definition of ‘Not Guilty by Reason of Developmental Immaturity’. This is a more scientifically sound position than doli incapax and would place the burden of assessment with psychiatrists and psychologists. Whilst this burden would in all probability be small (doli incapax was very rarely used as a defence) it is extremely important that we, as mental health professionals answer the call. Without this defence, an already disenfranchised group is left with minimal protection in the criminal justice setting, and we as a society will be accountable for how we have treated them in years to come.

REFERENCES


3 EGD (ii)


14 Gilliki v West Norfolk and Wisbech AHA [1995] AC 12

15 Paragraph 36.23 of the Mental Health Act Code of Practice (relating to the Mental Capacity Act)


18 T and V v The United Kingdom (Application number 24888/94) European Court of Human Rights judgment, Strasbourg 16th December 1999


20 MacArthur Adjudicative Competence Study, MacArthur Foundation Research Network on Adolescent Development and Juvenile Justice – inter alia, Norman Poythress, PhD, Steven K Hoge MD, Richard J Bonnie LLB, John Monahan PhD, Marlene Eisenberg PhD

## Events calendar
For more on forthcoming events, please visit www.acamh.org/events

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Event Description</th>
</tr>
</thead>
</table>
| 7 NOVEMBER | GLASGOW        | Conference  
New approaches in mental health provision for children and young people with learning disability                                      |
| 13 NOVEMBER| BURY ST        | Conference  
The role of words in early language development: current understandings and interventions                                                   |
| 14 NOVEMBER| YORK           | Conference and AGM  
Bipolar disorder in children and young people in the UK: a Northern perspective                                                           |
| 20 NOVEMBER| LIVERPOOL      | Conference  
The application of Mindfulness based techniques with young people and their parents                                                               |
| 21 NOVEMBER| CARDIFF        | Conference  
Mindfulness                                                                                                                                       |
|           | NEWCASTLE UPON TYNE | FREE SEMINAR PRESENTED BY BARNARDO’S  
Understanding the sexually abused child: principles in therapy                                                                                   |
| 3 DECEMBER | LONDON         | Twilight Meeting  
Early interventions                                                                                                                             |
| 5 SOUTHAMPTON |             | Conference  
Hearing voices                                                                                                                                     |
|           | GLASGOW        | Twilight Meeting  
Mentalisation                                                                                                                                     |
|           | IPSWICH        | Conference  
Inside I’m hurting (Louise Bomber)                                                                                                            |
| 13 MARCH   | IPSWICH        | Conference  
Paediatrics and mental health                                                                                                                   |
| 23 APRIL   | DURHAM         | Conference  
PaeDiatrics and mental health                                                                                                                  |

For more on forthcoming events, please visit www.acamh.org/events
We have been invited to write a short summary of Scottish Legislation relevant to CAMHS. This article aims to provide a brief overview.

**Getting it right for every child**

The Children and Young People's Bill (2014) embeds the rights of young people into legislation with a focus on wellbeing as opposed to welfare and safety. It formalises the principles of ‘Getting it Right for Every Child (GIRFEC)’ (2004) which initially focussed on the Children’s Hearing System but was later developed to apply widely to the delivery of children’s services. It was here that the SHANARRI indicators were first proposed. Principles consistent with the UN Convention on the Rights of the Child are central to this set of wellbeing indicators.

The National Practice Model (Figure 1) is applicable to single agency, multi agency and interagency working.

**The children’s hearing system**

The Children’s Hearing Scotland Act 2011 governs and oversees the hearing system, which considers those in need of care and protection and those who commit offences. Referrals can be made by anyone with concerns; most commonly professionals from Social Work, Education, Health or the Police. The Reporter will gather relevant reports and make a decision about the need for a hearing. The Panel consists of three lay people who have had specific training and will hear from the child and other parties before making a decision. If grounds are contested then the case may be sent to the Sheriff Court for proof. Statutory measures are only used if necessary.

**The Mental Health (Care And Treatment) (Scotland) Act 2003** (hereafter referred to as the act)

The Mental Health Tribunal for Scotland (Practice and Procedure) Rules 2005 governs decision-making by Tribunals on care and treatment under The Act, which can be applied to patients of any age.

The Mental Welfare Commission, an independent organisation set up by Parliament, has a range of statutory duties under mental health and incapacity law (Visiting, Monitoring the Acts, Investigations, Giving information and advice, Influencing and challenging practice).

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*Figure 1: National Practice Model*
There are a number of civil detention powers highlighted in the table below:

<table>
<thead>
<tr>
<th>Detention</th>
<th>Period</th>
<th>Application by</th>
<th>Tribunal held</th>
<th>Right of appeal to tribunal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Detention (EDC)</td>
<td>Up to 72 hours</td>
<td>Approved Medical Practitioner (AMP) with Mental Health Officer (MHO) consent if possible</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Short Term Detention (STDC)</td>
<td>Up to 28 days (prior EDC not required)</td>
<td>AMP and MHO consent</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Compulsory Treatment Order (CTO)</td>
<td>Up to six months with extensions possible</td>
<td>MHO and reports from two AMPs or AMP and GP</td>
<td>For initial applications only</td>
<td>Yes</td>
</tr>
</tbody>
</table>

The patient must meet all of the following criteria in order to be detained under the Act:

- The patient has a mental disorder
- The patient’s ability to make decisions about the provision of medical treatment is significantly impaired as a result of that mental disorder
- It is necessary to detain the patient in hospital for the purpose of determining what medical treatment should be given to the patient or of giving them medical treatment
- There would be significant risk to the health, safety or welfare of the patient or to the safety of any other person if the patient were not detained in hospital.
- The granting of a detention certificate is necessary and the least restrictive option.

Key points within the Act address welfare, education and age appropriate treatment:

- **Section 23 (1) (b)** - Health boards have a duty to provide suitable services for the admission and treatment for children.
- **Section 26**: There is a duty to look after the patient’s social needs and welfare. The named person is the person who has parental rights for the under 16 year old. If there are two people with parental rights and they cannot agree on who the named person is, then it is the primary carer. The named person can also be the Local Authority.

**Cross border transfers**

The Mental Health (Cross border transfer: patients subject to detention or otherwise in hospital) (Scotland) Regulations 2005, specify the duty and roles of persons or agencies involved in the application and procedures of cross border transfers. Scotland does not have inpatient facilities to treat children and young people with Learning Disability and/or high Forensic Risk and concurrent mental health difficulties but may seek to develop these in the future.

**The Criminal Procedures Act (Scotland) 1995** Part V And VI

This Act is occasionally used in circumstances when a child (under the age of 18) has committed a crime and there are sufficient concerns about his/her mental health. More detail is included in the online article.

**The principle of consent**

The principle of consent should be observed wherever possible. Section 2(4) of the Age of Legal Capacity (Scotland) Act 1991 states the following:

*A person under the age of 16 shall have legal capacity to consent on his own behalf to any surgical, medical or dental procedure or treatment where, in the opinion of a qualified medical practitioner attending him, he is capable of understanding the nature and possible consequences of the procedure or treatment.*

**USEFUL RESOURCES**

- www.legislation.gov.uk
- www.chscotland.gov.uk
- www.scotland.gov.uk/topics/people/young-people/gettingitright
Deaf children and young people are at a higher risk of mental health difficulties, and yet are less likely to access mainstream services. There is therefore a national network of highly specialist regionally commissioned National Deaf CAMHS service to work with deaf children and young people and hearing children of deaf parents.

This article will describe the experience of deaf children in the UK, including the risk factors for mental health problems, the issues in accessing services, issues for mainstream services to consider in order to meet the needs of this group as well as information about the national deaf CAMHS highly specialist regional services.

Deaf people
There are around 70,000 deaf adults in the UK who are part of the deaf community, in that they share a language (British Sign Language), life experiences and a culture. Within the deaf community, deaf people feel they belong to a cultural and linguistic minority, as opposed to having a disability. Their experience of the world is predominantly visual, however as the world around us is predominantly designed for hearing people, lack of provision through visual means will therefore put deaf people at a disadvantage compared to their hearing peers. This means they will experience a lack of access to auditory information which therefore creates something people refer to as a ‘fund of knowledge deficit’.

The Newborn Hearing Screening Programme is identifying around one in one thousand babies at birth and a further one in one thousand are identified in childhood, allowing for early support in developing good family communication. It is now routine that deaf children are offered cochlear implantation, although there remains controversy around this issue within the deaf community in terms of lack of informed choice. Cochlear implantation does not mean that the children will hear like hearing children, more that they have access to some sounds which they can learn to interpret when they have the device on.

Deaf children and mental health
Deaf children are more likely to have emotional and behavioural problems than hearing children. Being deaf does not in itself cause mental health issues, but being deaf in a hearing world does increase the risk.

Some may have biological risk factors (such as neurological damage, birth trauma or genetic conditions) and all of these affect the rates of mental health problems. At least 90% of deaf children are born into hearing families that are unprepared for the communicative challenges that they face and this can affect access to good communication and relationship development. Communication problems are associated with increased rates of mental health problems.

Anxiety disorders are more common and often present with behavioural issues. ADHD appears to be more common particularly for those that have become deaf later on in life and those with cognitive impairment. Autism spectrum conditions are more common, although assessment is more complex. Deaf children are more likely to have been sexually abused and less likely to disclose.

The experience of the service nationally is that deaf children present with a high level of behavioural difficulties as an externalising response to low mood, anxiety, abuse and social and emotional developmental delay. There are challenges in assessing other mental health problems accurately due to the cultural and linguistic differences. Psychotic experiences have been historically harder to phenomenologically clarify due to the patient quite often using a different language from the clinician. New models of working with interpreters in mental health have meant that this is being bridged.

National Deaf Child and Adolescent Mental Health Service (NDCAMHS)
The Deaf Children, Young People and Family Service provides a specialist mental health service for deaf children and young people who have a severe to profound hearing loss in addition to significant emotional and behavioural problems.

We accept referrals for:
· Children who are deaf or have a hearing loss
· Hearing children with a parent who is a BSL user, or has a severe or profound hearing loss

As well as direct work with young people and families, we offer consultation to or co-working with other professionals involved in supporting deaf children – CAMHS, education, social care, audiologists, cochlear implant teams, voluntary services.

The teams are multi-disciplinary with a mix of both deaf and hearing professionals. All staff are working towards a high level of British Sign Language. All staff acquire expertise in the developmental/linguistic and cultural aspects of being deaf alongside an expertise in mental health problems. A team around the child model is utilised in order to see the family from all perspectives and experiences to support a young person and their family.

Children, young people and their families can access services within ten centres throughout England, organised into four regions nationwide. Access to a centre should be determined by need and ease of travel for the family concerned. There is a national inpatient unit in London which has six beds for those young people aged 8 – 18 who need more intensive assessment or treatment.

A core part of the assessment is to undertake a communication profile, which looks at the child/young person’s language/communication and access to their environment at home, in school and in 1-1 settings. Clearly, ensuring the linguistic needs of the child are correct is vital for the assessment. Some children will predominately use spoken English, some will use BSL, some will use a signed English approach. Some deaf parents may produce an idiosyncratic use of sign language and therefore require a deaf interpreter.

A wide range of therapeutic interventions are offered, such as individual therapy, specialist family therapy or group work. We always adapt and adjust our therapeutic interventions to be accessible, using visual materials as opposed to the use of predominately talking therapies etc. We also use BSL video letters.

We are in the process of developing care pathways and intervention packages. Common interventions involve highly
adapted CBT, emotional literacy and regulation packages, social story based anxiety and behaviour management packages. Another key area of work is enabling the understanding of deaf identity for the young person and family based interventions around communication, understanding and relationship building.

**Working with British sign language/ English interpreters**

One of the areas that our service has evolved is working with interpreters within the whole process, incorporating a more robust working together model, in particular within clinical settings.

BSL is a language in its own right, which means it has its own grammatical features and syntax. Interpreters have been trained in working in a particular way in order to work in different settings. They also have a clear code of conduct and should be appropriately registered. Although there is no specific training for interpreters in mental health, as a service we pride ourselves in providing bespoke training to equip interpreters to work as effective as possible in this highly specialised arena.

It is our standard practice, given the complex nature of the work and the paramount importance of taking into account the linguistic and cultural aspects of what the family need, that we would meet with the interpreter before the session to clarify the background and aim of the session together, and then to meet following the session to discuss any particular communication or process issues. If a piece of therapeutic work is to be ongoing, it is vital that we work with the same interpreter throughout. In this way, there is consistency and containment for the deaf child.

**Conclusion**

In summary, this regionally commissioned national service can work directly with a complex group of young people and has developed considerable experience and expertise over the five years. We are keen to work with local CAMHS to ensure best support for deaf children and families and are very open to consultation and discussions.

Further information with the contact details of the teams is on the website http://www.dcfs.org.uk

SOPHIE ROBERTS, CONSULTANT CHILD AND ADOLESCENT PSYCHIATRIST AND RACHAEL HAYES, DEAF SERVICE CONSULTANT

**REFERENCES**


Association for Child and Adolescent Mental Health Special Issue.

Gender identity and children with autism spectrum disorder

Definitions and classifications

Gender identity is the private sense and subjective experience of one’s gender. For most, a natural understanding develops from a child’s early months and years without difficulty or conflict and is in line with the gender that is assigned at birth. For some, however, there can be a growing feeling of incongruence between their external body and internal experience. This can result in significant distress and a desire to change.

This phenomenon is a recognised disorder in childhood (as well as in adults) and diagnostic classifications are outlined in both DSM-5 as ‘Gender Dysphoria’ and ICD-10 as ‘Gender Identity Disorder of Childhood’.

Epidemiology

Whilst considered rare, the actual incidence of Gender Dysphoria (GD) or Gender Identity disorder (GID) in the child and adolescent population is difficult to ascertain due to the lack of epidemiological studies and problems with differing criteria across the globe. Rates of referrals at all ages are increasing. A survey of 10,000 people undertaken in 2012 by the Equality and Human Rights Commission found that 1% of the adult population was gender variant to some extent. We know that Gender Dysphoria in adults knows no cultural boundaries, although it may be more hidden in some, and there is nothing to suggest that it is any different in child and adolescent populations.

It was once thought to be more common in natal boys, however, over recent times the number of girls presenting has increased and some studies report more equal numbers. The sex ratio seems to change according to age with a higher male: female ratio in under 12s compared with over 12s where the ratio is close to 1:1.

In comparison to adults, there are differences in the fluidity and variability in the outcomes within the child and adolescent population. In a minority of prepubertal children with GID, this will persist into later life although many will develop a homosexual orientation. In adolescents, a higher proportion will pursue gender transition although there are also high rates of homosexuality.

GID in Autism Spectrum Disorder (ASD)

This is an area which has sparked some interest, but there has been limited research thus far. Reports from gender identity clinics and some studies suggest a putative link, revealing higher rates of co-occurrence than would be expected by chance alone.

Preliminary results from a recent surveillance study of children and adolescents in the UK and Ireland reported ASD in 17/105 (16%) of new cases of GID over a 19 month period. One study from the Netherlands found ASD in 6.4% of children referred to a Gender Identity clinic and 9.4% in the adolescents referred. The Tavistock and Portman NHS Foundation Trust, which provides a Gender Identity Development Service for under 18s in the UK, estimate around 10% of their referrals have ASD. This finding is interesting and relevant for diagnosis and management and raises important theoretical questions.

In order for us to try and understand this further it may be helpful to outline ‘typical’ gender development and see how having ASD may impact upon this.

Gender identity development is influenced by biological, psychological and social variables. Kohlberg (1966) proposed that a child moves through three stages of increasing complexity.

1 Gender identity
   By two a child is able to self label.

2 Gender stability
   By four the child understands that gender remains the same across time.

3 Gender constancy
   By seven a child understands that gender is independent of external variable such as the way people have their hair or dress.

In gender schema theory, a child creates a cognitive structure which is used to organise information about an object, person and situation. Information is ‘made sense of’ by matching their pre-formed schemas. It is therefore perhaps understandable that a child with ASD and associated difficulties such as with social interaction, communication and theory of mind deficits may struggle to form an understanding of their often ambiguous environment in order to reach an awareness of their own gender. If development is delayed at an earlier stage, for example if there is an associated intellectual disability, they may display more rigidity in their gender beliefs.

Within the literature exploring the area of ASD and GID a number of theoretical explanations have been discussed. Whilst some of this research comes from child and adolescent populations, some is also extrapolated from adults.

It has been suggested that a confusion of identity in ASD may expand to gender related problems. The sense of ‘not belonging’ in ASD is a common experience with those who have GID, thus GID may arise due to their ill-defined sense of being different from others.

‘An adolescent with ASD who always had the feeling of being different from his peers in childhood, but had no history of childhood cross gender behaviour, became convinced that this feeling was explained by gender dysphoria. He had hoped that his communication problems would alleviate by taking hormones’.

Another proposed theory is linked to difficulties with social and interpersonal relationships. There are reports of it arising as a consequence to bullying, difficulties in ‘conventional’ sexual relationships, abuse, sexual difficulties, or a paraphilic consequence of impairments in social interaction.
It has been suggested that GID could be regarded as a sequel to Asperger Syndrome (AS) in natal females arising from male emotional and cognitive traits due to AS. One would expect in this case natal females with ASD to outweigh natal males with ASD in referrals to GD clinics, however, this does not appear to be the case in the literature or clinical practise (although there have been no confirmatory studies around gender ratio in this specific area).

Some may view GID and associated behaviours as part of the unusual interests and preoccupations seen in ASD. However, such gender related behaviours, which include: mannerisms, attitude, interests, preoccupations and self identification show a broad spectrum rather than the restricted repertoire seen in ASD.

Could GID be an obsession/compulsion in ASD linked to behavioural rigidity and obsessionality? Parents often report that their child is obsessed by issues surrounding gender. However, being in preferred gender role is in itself egosyntonic (excluding any social difficulties and anxieties which may arise). A case in the literature of a girl with ASD found her OCD symptoms resolved with medication, but the gender related ideas persisted.

Sensory preferences have been noted in some individuals. There are reports of fascinations in typically ‘feminine interests’ such as silky, soft and glittery textures and materials, bright and shiny substances and long hair. This could potentially explain some cross gender behaviours in natal males.

Clinical experience and the literature appear to support the co-occurrence of GID and ASD. Successful treatment also seems possible, however, it is important to take the neurodevelopment disorder into account. The Tavistock and Portman service accept referrals of young people with ASD. Whilst unpicking the inter-relatedness of GID and ASD is a complex task, positive outcomes are reported. This area increases in complexity if an individual has an additional intellectual disability and/or limited verbal skills. In clinical practise, best interest decisions have been made in non-capacitous individuals.

Assessment and treatment
Assessment of children and adolescents presenting with GID must be comprehensive and include their family. Important considerations are the high rates of co-existing internalising disorders such as anxiety and depression, and/or externalising disorders such as oppositional defiant disorder, in addition to the possibility of neurodevelopment disorders such as ASD. Adolescents with GID are at a high risk of self harm and suicide attempt especially in the over 12s.

An important focus of treatment is to explore an individual’s gender identity. Clinicians have a crucial role in alleviating distress, fostering recognition, acceptance and openness in order to break the ‘cycle of secrecy’ that surrounds this issue for so many of those affected. Families, who themselves may be experiencing a mourning process, may need support to move away from a binary view of gender, to manage uncertainty and sustain hope.

Treatment aimed at trying to change a person’s gender identity and expression to become more congruent with their natal gender has been attempted in the past without success and is not considered ethical. Following assessment and diagnosis of a child or adolescent with GID subsequent treatment follows a staged approach.

Stage 1
Further exploration of the nature of gender identity
Stage 2
Reversible interventions – hormone blocking from 15 years (12 years in research)
Stage 3
Partially reversible interventions – cross sex hormones
Stage 4
Irreversible interventions – surgical procedures (not considered before 18)

Summary
Gender identity can be viewed as a developmental milestone. Rates of referrals to GID clinics are increasing. Whilst evidence base is limited it suggests a higher rate of GID in those with ASD. This raises important theoretical questions about the neurodevelopmental mechanisms at play. Assessment and treatment of those affected is complex and requires an individualised approach however the literature also supports treating GID in those with ASD in accordance with international standards.

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Ireland branch annual research day winners
17 May 2013, Trinity Centre, St James’ Hospital, Dublin

**Poster prize winners**

Ms Aoife Fitzpatrick  
Surviving the Leaving Cert: An analysis of stress and coping in final year secondary school students

Dr Gary McDonald  
Patient and Parental Experience and Satisfaction in an Adolescent Inpatient Psychiatric Service

**Oral prize winner**

Dr Helen Coughlan  
Prevalence Rates of Mental Disorder among Young Irish Adolescents: findings from a population-based study

**Eadhbhíard O’Callaghan prize**

Dr Brian Merriman  
These kids fall between too many stools: Professionals’ views on the mental health needs of children and young people in the care and youth justice systems
Background

A series of paintings has been commissioned by ACAMH from Karyn Ambridge, our Conference Department Branch Administrator, who is also a painter with a BA (Hons) in fine art from Portsmouth University.

Each is a painting of a bridge in the locale of a branch’s region. There are 17 regional branches, and so far ACAMH have four paintings, which will be displayed in the head office building at St Saviour’s House.

The painting shown here is the Prince Albert Tamar Rail Bridge, entitled ‘Tamar’. It is a 20 x 23.5 in. (50x60 cm) oil on canvas, painted for the Devon and Cornwall branch.

About the Royal Albert Bridge

The Devon and Cornwall branch chose the Royal Albert Bridge as it spans the border between Devon and Cornwall, joining the two counties together.

The bridge itself is an iron construction built by Isambard Kingdom Brunel. It spans the River Tamar in England, between Plymouth, on the Devon bank, and Saltash on the Cornish bank.

Its unique design consists of two 455 feet (138.7 m) lenticular iron trusses 100 feet (30.5 m) above the water, with conventional plate-girder approach spans. This gives it a total length of 2,187.5 feet (666.8 m). It carries the Cornish Main Line railway in and out of Cornwall.

Alongside the Prince Albert Bridge; the Tamar Road Bridge is visible, joining the A38 between Devon and Cornwall. In 2001 it became the world’s first suspension bridge to be widened (from three to five lanes) using cantilevers.

The inspiration

Although this landscape is crossed with heavy industrial metal structures, the view, with a slight mistiness prevalent on the warm spring morning that I visited, was an atmospheric contrast, and the scene had a playful feeling of light patterns softening the hard cold blue grey iron and steel.

ACAMH Devon and Cornwall branch

The Devon and Cornwall branch’s main hub of activity is centred around Torquay and Totnes in Devon, and on occasion in the past has had events in both Exeter and Plymouth. The branch is small with 45 ACAMH members, but has a large contingent of non-members who regularly attend events.

Derek Smith, Branch Chair and Educational Psychologist, has been a member of ACAMH for nearly 22 years and along with committee member Kitty Howarth, Educational, Child and Community Psychologist, put on at least two medium-sized events every year. The subjects covered have included anxiety in children and young people, learning disabilities, eating disorders and disorganised children.

Derek and Kitty are keen to find new committee members for the branch to help organise their annual event programme. If you are local to the area, please get in touch.

karyn.ambridge@acamh.org

ACAMH Conference Department Branch Administrator

KARYN AMBRIDGE, ACAMH CONFERENCE DEPARTMENT BRANCH ADMINISTRATOR
THE CHILD AND ADOLESCENT PSYCHIATRY
Surveillance Service (CAPSS) has just celebrated its fifth birthday. CAPSS supports the collection of incident data from consultant child and adolescent psychiatrists across the UK and Ireland for rare disorders and events that would be difficult to study using other methods. The report documents the studies completed to date, some of which have been carried out in collaboration to the long established British Paediatric Surveillance Unit and some of which have led to international replications. As well as avoiding the selection biases inherent in case series from centres of excellence, surveillance raises awareness of rare difficulties and has changed policy and practice.

Happy birthday CAPSS
The Child and Adolescent Psychiatry Surveillance Service turns five

CAPSS works by contacting all consultant child and adolescent psychiatrists each month to ask if they have seen a case that should be reported for whatever studies are currently running. The consultant sends back a card with their answer (yes or no; no responses are really important too) and consultants who report cases are then contacted with a brief questionnaire to highlight the characteristics of the child and family, and planned management. Follow up questionnaires are sometime sent to get more details about management. Look out in the autumn for the CostEd study, led by Professor Sarah Byford, a health economist, who is studying the cost-effectiveness of different types of services for children and young people with anorexia.

Sadly, at the moment we can only work with psychiatrists, so studies can only focus on difficulties that they would tend to be consulted about or see directly. We hope that this will change over time. We also see a role in relation to supporting trainees to gain experience of research and methodology.

Please get in touch with any ideas about questions you think would make good studies or if you are interested in getting involved in what we do.
CAPSS@rcpsych.ac.uk

The CAPSS report can be downloaded from http://tinyurl.com/report-capss

TAMSIN FORD, CHAIR OF CAPSS EXECUTIVE COMMITTEE

ACAMH West Midlands workshop, National Deaf CAMHS
19 June 2014, author Madan Mall

THE PRESENTERS GAVE a very interesting and informative introduction to the work of Deaf CAMHS. Deaf children are more likely to experience mental health problems than their hearing peers and can have difficulties accessing mainstream CAMHS. For children who are severely or profoundly deaf, the Deaf CAMH service works alongside local CAMHS to support them and their families. Children who are mildly deaf and whose communication is less compromised can access local CAMHS. The Deaf CAMH service, working jointly with local CAMHS, will also see the hearing children of deaf parents.

Dr Walker described how national Deaf CAMHS enhances local CAMHS delivery through co-working. Deaf CAMHS values both the medical and cultural models of deafness. While being deaf is clearly a disability, it is unhelpful to ignore the different language, social relationships and shared experiences that are important aspects of the deaf community. Using a cultural model to understand deafness means seeing deaf children as different but equal to hearing children and results in higher expectations and potentially lower rates of mental health problems.

Around 90% of deaf children are born to hearing parents who may have had little prior experience of deafness. Dr Walker explained that the priority for deaf children is learning to sign and that early exposure to sign language leads to better social and educational outcomes. Cochlear implants have become popular, but they do not suit all children and results are unpredictable and variable and Dr Walker advises using a bilingual (sign plus speech) approach to maximize the opportunities for learning.

Dr Farthing presented the complex case study of a girl, now 16, who was diagnosed deaf at the age of three and developed significant mental health problems in adolescence. The case illustrates a number of issues: the experience of a deaf child in a hearing family, late diagnosis of deafness and the gap in development that results, the use of cochlear implants and the subsequent reliance on speech rather than signing, the bullying and isolation that a deaf child may experience from hearing peers, the ambiguous identity of a deaf child in a hearing environment, the difficulty in knowing whether the child’s mental health problems stem from being deaf or from other unrelated factors such as her diagnosis of Pendred syndrome, and the difficulties of making a diagnosis.

The case sparked an interesting discussion about how best to co-ordinate care as the girl had in-patient and outpatient treatment from two different Trusts resulting in boundary issues.

Helen Farthing and Peter Berridge gave a most enjoyable and interesting presentation on deaf awareness conducted entirely in sign language. The audience was provided with a spoken translation by sign language interpreters. Ms Farthing and Mr Berridge described their own experiences of being deaf and talked about the ways in which hearing is restricted as deafness moves from mild to profound. The speakers introduced various communication techniques such as cued speech, signed supported English, sign language, and registered sign language interpreters, and discussed things that hearing people should consider when communicating with the deaf.

The presentation ended with a memorable film that showed the huge frustrations felt by a deaf teenager and communication breakdown that results when parents have not learned to sign.

Deaf CAMHS is based at Boundary Brook House, Churchill Drive, Headington, Oxford
Convergence of technical and social platforms and services in the new communication media, and the ease with which users interact across multiple platforms and devices, has been embraced by children and young people who increasingly move effortlessly between the various interactive services and devices to communicate their active participation in online communities presents increasingly dynamic and innovative opportunities as resources diversify and potentials become possible, yet it also gives rise to additional risks in terms of safety such as cyber bullying and potential abuse and online predators. The conference encompassed a holistic framework to reinforce the interloping relationship and focus on the key issues, developments, advantages and impacts.

**Online risk, harm and vulnerability- where’s the harm?**

**Sonia Livingstone**
Professor of social psychology; Director of the EU Kids Online network, London School of Economics and Political Science

Livingstone demonstrated the challenge of building an evidence base for policymakers within the fast and ever changing cyber-space domain. There is need to focus on identifying the children who experience risky situations on the internet and how to understand the harm that might follow. Her presentation focused on the pattern between risk, harm and the vulnerability of some children at different points in their lives; recent work appears to be finding a more contingent, multi layered and multi stakeholder approach in term of managing cyber-spaces, allowing some freedom but also regulation. Livingstone concluded that limitations and variables to consider include the psychological vulnerability of the child, factors that have not yet been identified and the limitation of self-reported data; both under reporting and over reporting.

**Online addiction in adolescence**

**Mark Griffiths**
Professor of Gambling Studies, International Gaming Research Unit, Notthingham, Trent University

The focus of Griffiths’ talk was online gaming addictions and online video game addictions. The internet is attractive due to its accessibility, affordability and its anonymity. He discussed six components that he would operationalise as a genuine addiction; Salience; the behavioural addiction take over all cognitive and behavioural presence; mood modification; a consistent and reliable shift in mood state; tolerance; needing more of the behaviour to create the same mood modifying effects; conflict; the activity causing conflict in your life or intrapsychic conflict; relapse; after giving up people engage in the behaviour cycle again. There is often a social, physiological, psychological or financial award derived from video gaming. Griffiths’ illuminated limitations such as instruments used to measure addiction are not valid or reliable; appearing to overinflate problems. Often surveys do not often consider severity and do not account for the context of playing.

**The digital see-saw; balancing risk and benefits**

**Jenny Hyatt**
Chief Executive and Founder, Big White Wall (award-winning digital mental health and wellbeing service)

Big White Wall began at a time in 2008 when there was a huge amount of debate around the Bridgend suicide pacts. Big White Wall’s biggest consumer is the National Health Service and likewise, their biggest market is the National Health Service. Risk adversity is a serious issue alongside enabling people to work within their own risks limits. Hyatt discussed the development of the initial prototype and the processes of its development. The management of safety on Big White Wall is paramount to Hyatt and her team; with rigorous clinical governance, standard clinical instruments, monitoring risk communication patterns and a clear supervisory system. Hyatt’s take home message was not to let the small minority of people ruin the space assuring that people do use facilities correctly and with the right kind of procedures in place, the safety of all will be there.

**E-therapies and the creation of SPARKX**

**Sally N Merry**
Associate Professor, Head of Department of Psychological Medicine and Director, Werry Centre for Children and Adolescent Mental Health, University of Auckland, Zealand

According to Merry the rationale for e-therapies is clear; there are simply not
enough therapists. The presentation gave a detailed and informative description of her journey overseeing the development of an e-therapy called SPARKX; a youth friendly interface. SPARKX was designed with the help of young people; its concept included a young person interacting with a mentor incorporating a two-way interchange. Clinical trials have supported the use of SPARKX but also illuminated implications and risks such as how e-therapies should be distributed (freely versus prescription), monitoring and clinical overseeing, reaching outside target populations and IT risks such as data storage, encryption, formats and potential bugs. Merry concluded that there is cause to rethink the structure of clinical trials; research methods must suit IT interventions. IT interventions could spark a worldwide openness, with excellent interventions for our future generations.

Harness media and technologies to benefit children and families
Rachel Calum
Professor of child and family psychology, University of Manchester

The presentation suggested that strong measures are clearly needed to reduce problematic parenting and technology offers many possibilities to address this. Calum discussed her work on the Triple P positive parenting programme. Numerous trials of Triple P online have taken place, creating capacity for reaching a large number of parents. Calum’s research began to focus on addressing particular needs parents have, specifically parents with bipolar disorder; their children experience a lot of inconsistencies in parenting. Using online resources, a survey was conducted that led these parents into a randomised control trial. 17% of these parents were waiting to see or seeing mental health services, on behalf of their child also, suggesting further need for services to be easily accessible. The talk closed focusing on the key point that research is showing there are tremendous opportunities to reach populations via technology that previously have not been reached.

The importance of ‘internet psychology’ in clinical risk management and service delivery
Richard Graham
Consultant child and adolescent psychologist, Tavistock and Portman NHS Foundation Trust, Tavistock Centre

According to Graham, to understand subsequent behaviour, one has to keep in touch with recent trends as the world evolves rapidly. Graham suggested that perhaps research needs to be less mindful of clinical work and focus on the research that emerges from market research, understanding factors that make influence individuals and what causes them to be vulnerable.

Ephemeral apps such as Snapchat, (a fast media creation enabling us to communicate through photos) are fun; a reward and response effect is apparent. Young people clearly thrive in this environment and Graham believes this element needs to be embraced. Graham closed his presentation demonstrating that clinicians need to have the capacity to think digitally about where client’s minds are and how devices and apps are incorporated into their mental functioning or emotional experiences, becoming a neutral part of our assessment and therapeutic thinking.

- The capacity to form, change and create multiple identities which exist in perpetuity, cyber-space is allowing a complex mix of anonymity, self-promotion and role play.
- Media and technologies have enormous potential for good. They have offer the best chance of accessing large numbers of families, who would not otherwise be in contact with services and helped; the out of target population may become reachable.
- Clinicians need to have the capacity to think digitally about where client’s minds are and how devices and apps are incorporated into their mental functioning or emotional experiences.
- Helping children to anticipate risk and to think carefully about options, is a way of building resilience that’s relevant across the whole range of risks that children and young people may face.

JENNIFER MRZIK, ASSISTANT PSYCHOLOGIST, TEES ESK AND WEAR VALLEYS NHS FOUNDATION TRUST

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By joining ACAMH you’ll receive

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- Additional online resources such as podcasts or slides of past ACAMH events, output produced by our special interest groups, and expert guides on key mental health topics
In recent years the rise in use and application of e-space and associated technologies has impacted on how we as an organisation educate and support our children and young adults. It has also brought about changes in my own and my staff’s working practice. I would like to share with you the positive aspects of this technology and also present some of the associated difficulties that the use of these technologies sometimes unexpectedly throws up.

Background

KTS Academy (formally Kilton Thorpe Special School) is a specialist academy that caters for children and young adults with a range of special educational needs. There are 150 places for children between ages 3-19 and there are approximately three boys for every girl. In recent years, as in most special educational provision, the educational, emotional and health needs of the children have significantly changed and the academy has had to adapt and develop its training and resources accordingly. We have far fewer children with severe learning disabilities (SLD – historically labelled as ‘slow learners’). We have an increasing population of children with a diagnosis of autism (50% and rising compared to 15% just a few years ago).

In addition we have a large population of children with complex learning difficulties and disabilities (CLDD). These children have conditions that coexist with one or more special educational needs and interlock creating a complex profile. The children and young people with CLDD present with a range of issues and combination of layered needs, e.g., mental health, relationships, behavioural, physical, medical, sensory, communication and cognitive. They require informed specific support and strategies which often include trans-disciplinary input to engage effectively in the learning process and to participate in the classroom and indeed the wider community.

It is therefore essential that we continue to develop and foster a close working relationship with therapy and medical staff. We also work very closely with our families and family support agencies. We do not treat all children the same. The challenge is to ensure we give them the same opportunities whatever barriers exist to hinder us from achieving this.

Ten years ago as a newly appointed head, my first task was to introduce into the staffing structure a school counsellor/play therapist to support the pupils’ emotional wellbeing. It is important to note that many of the children and young people within specialist educational settings are very aware that they are ‘different’ to the peers within their communities. Not only do they have to address the emotional roller coaster that adolescence brings to most teenagers, they also have the challenge of dealing and coming to terms with their disability/difficulties. I also undertook a complete audit and review of the ICT resources and associated technologies and produced my first of many development plans focusing on ICT and associated training and resources.

The findings from that first audit indicated that there were limited e-learning opportunities. The school did not have a website or its own school network. There was no e-learning portal or indeed an expected use of emails by staff or other professionals. The majority of the technologies used to support teaching involved connecting pieces of equipment together via cables and most had to be connected via the mains. The limited numbers of computers the school had were large desktop PCs.

Over the subsequent years there has been a great deal of development and investment in e-learning and the associated technologies both with the larger whole school resources such as the sensory rooms – including the light room and hydrotherapy pool areas – and also in deploying specific handheld devices used by individual pupils.

We are constantly adapting what we do to support and challenge our pupils in all areas of our pedagogy and learning. We have embraced new technologies and if you visited the school now you would see all classes using new technologies to support learning and organising. I would like to highlight three examples of this.

The internet

An area that has significantly developed over the years involves using the internet to access appropriate material and information as well as to support communication. The school now has a website with associated links to a variety of cloud base hosting sites. This brings with it its own issues around e-safety and restricted access. Emails and electronic diaries are used to keep staff and parents informed and updated. The school also has its own intranet where programmes and online sites can be accessed.

E-safety is an extremely important component of our PSHE curriculum and we revisit this theme – especially with our older groups – many times throughout the year. Due to our rigorous safe-guarding policies and procedures which includes the filtering software applied to our broadband connection, the materials and use of the internet and social networking sites are strictly controlled and limited.

However many of our pupils and students access the internet away from school and this has sometimes lead to problems for a small group of pupils. Many children have relatively easy access to inappropriate materials in the home settings. A number of our children find it difficult to differentiate what is real and what is entertainment and with more content made available via the internet and increasing TV channels, our children are exposed to a great deal of material which can have direct consequences on their emotional wellbeing and presentation at school.

Although we do not allow access to social networking sites within school, they are used at home by many of our older pupils and students. Whilst these sites can be a great opportunity for our young people to stay in touch and communicate with each other, many of our students are geographically and socially isolated and can find it difficult to interact face to face. These sites and the use of emails can and sometimes does become used to intimidate and bully. Our teenagers are vulnerable at the best of times however the use of social networking sites can cause a great deal of distress and anguish both for them and their families. We have had cases where individuals and families become extremely abusive and threatening to one another via these sites. This then can be carried on with the school setting and we are left to try and manage the resulting fall out.

Animation and filmmaking

An exciting area of expertise the school has developed over recent years is using and applying digital technology to the creative process of animation and filmmaking. We have a suite of rooms where students using this technology can create and edit their own films. This has been a great success and many students have had excellent achievement in this curriculum area. Many of our students are naturally drawn to this area of the curriculum and through the media of animation and film it allows them to draw on their creative side. The students have won several regional prizes over the years for both the standard and quality of both films and animation. These films and pieces of work can of course be seen by a much wider audience as they are available to watch via hosting sites which friends
and families can access. We have also had students who leave us and go on to college to pursue film/media courses.

**Handheld devices**

A third area of technology that has blossomed in recent years is the use of handheld devices which have obvious advantages over desktop PCs and laptops. They are extremely portable and the majority of apps can be accessed speedily. They offer a wide range of programmes that can be used across ability and age ranges. These include cause and effect apps which are useful for children with profound needs through to some art and design applications which, when finished, can be blue-toothed to the printer to produce a 3D model quickly and efficiently.

No longer do we have to take children to the ICT Suite and dedicated technology rooms, access to applications and the internet can be taken to them. Handheld devices are also useful for staff to quickly capture photographic evidence and within seconds upload it to the evidence file. An area where we have had mixed success with these devices is in using them as communication aids. They appear at first to be ideally suited for this use as they are portable and have quick access to suitable communication apps. However in our experience many of the children that were using these as aids to communicate wanted to access other apps, which distracted them from using them as a communication tool.

We have found that they can reinforce certain unsuitable behaviours, and ironically prevent the children from engaging with learning. These devices can feed into the obsessive/addictive nature that seems to occur with many of our children when using technology. Individuals become very adept at being able to access particular apps/programs and video/music clips which may not be what the adult teaching them wants. The obvious solution would be to prevent access to these programs/apps however this can lead to individuals quickly becoming upset and going into crises. This then can result in the devices being thrown or deliberately smashed. It is important to remember that given the choice many of our pupils would happily remain in front of a screen each and every day.

**Conclusion**

To conclude, does the use of e-technologies help or hinder pupils within a school such as KTS? Are there significant benefits? The obvious answer is yes, the pros far outweigh the cons. However it is important that we use these technologies wisely and consider carefully how to apply them to support learning: as in the case of using them as devices to aid communication. We have found that one way to encourage our pupils to use them for this purpose is to have two devices: one that they use for pleasure/recreational use and a different one that is only used as a communicate aid.

E-space and associated technologies are here to stay and we should embrace this technology to help educate and support our children. However, all children need to develop and be taught skills to effectively interact and communicate with others. The irony is that as this technology helps our pupils to access, communicate and perhaps control the world around them it becomes easier for them to stay withdrawn and drawn into virtual worlds and away from interacting with real people. We have to carefully manage this dichotomy and ensure that we continue to challenge our own pedagogical practices to ensure we give our children and young adults the best possible outcomes for their future.

If any readers would like more information or are interested in finding out more about the work of KTS Academy, please contact me.

KEVIN THOMPSON
HEADTEACHER, KTS ACADEMY
KTHOMPSON@KTSACADEMY.ORG.UK
**Introduction**

Working in Child and Adolescent Mental Health Services (CAMHS), we are interested in the views of our patients but gathering feedback is often challenging in many ways; it is usually sparse and collected from parents/carers, the process can cause clinicians anxiety – especially if it is negative, feedback must be reported/displayed to motivate patients and clinicians and it can be seen as a paper exercise.

The NHS Constitution has patient-centred care as key; encouraging feedback which is then used to improve services. There is a recommendation by the Government (Every Child Matters) that we ‘see services through the eyes of the child and family’, whilst the General Medical Council directs ‘one of the principles of revalidation is that patient feedback should be at the heart of doctors’ professional development’.

Existing feedback options for psychiatrists include:

- A questionnaire at patient discharge
- The RCPsych 360° appraisal service
- Online feedback services such as iWantGreatCare.org

These options all have limitations which include, for example, a lack of personalised feedback and low response rates.

Therefore, it was important that the scheme I created was quick and accessible to as many children as possible. Questionnaires have been developed specifically for CAMHS but I wanted a scheme which did not require higher levels of maturity, intellect or literacy.

**Aims**

The aim was to design a patient feedback scheme which would enable the gathering of high numbers of patient views in a quick, fun and cheap way. The feedback would be anonymous, optional and would have no impact on that patient’s direct clinical care.

**Method**

A pilot project was run with the 11 doctors in the specialist generic and intellectual disability CAMHS services in Sunderland, Gateshead and South Tyneside.

Each doctor was allocated a different coloured plastic counter and we had three boxes which patients passed when leaving the department. Each box was clearly marked with a green happy face, a red unhappy face or a yellow neutral face; there was no written text on the boxes and a simple explanatory poster was placed on the wall above.

At the end of each appointment for two consecutive months in 2013, the patient was given a counter. They were asked to post it in the appropriate box depending on their experience that day. They were told to be honest, and reassured it was anonymous. At the end of each month the total collected was compared to the total issued to calculate a response rate.

**Results**

Those doctors who agreed to take part completed a questionnaire at the start. All but one were aware that in order to

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**PILOT PROJECT RESPONSE RATE**

- 93.9% Responded
- 6.1% No response
revalidate they needed to show evidence of patient and carer feedback. Half were not collecting any form of patient feedback and the most common reasons given for this was a lack of time and embarrassment when asking patients to do this.

Generally, they were using either no system, or systems which provided a low response rate, involved a lot of effort on their part to explain and collect feedback and which involved a high degree of effort by the patient or carers to provide the feedback. The level of satisfaction with these schemes was low.

During the pilot period, 491 counters were handed out, 461 were returned (response rate = 93.9%). In the first month, 80% were posted in the green box, 14.7% in yellow and 5.3% in red. In the second month, 83.8% went in green, 3.7% in yellow and 12.5% in red. There was variation between individual doctors.

A follow-up questionnaire was distributed at the end of the pilot. The doctors were asked about their experience of using the scheme. It was considered easy to explain, easy for patients to provide feedback and easy for doctors to receive results. They thought that the response rate was much higher than other feedback schemes.

The majority of doctors felt this scheme met the requirement for appraisal and revalidation, although three expressed an uncertainty as to whether it would be sufficiently detailed. All but one of the doctors were happy to continue using it. The overall satisfaction rate with this scheme was high.

The free-text comments received from the doctors were generally positive and included the following:

(\textit{It's an} excellent scheme which should be rolled out across the wider MDT, if embedded as ‘normal’ practice, it breaks down some of the barriers preventing feedback.

Discussion

The adult patient experience in acute hospital care receives most attention; comprehensive reviews such as that by The King’s Fund which has not looked at either mental health or children’s services. The Friends and Family Test, announced by PM David Cameron, is intended to be used for over-16 year olds who attend Accident and Emergency or who are inpatients only. This scheme had a remarkable response rate well above the minimum expected rate of 15% required by the Friends and Family Test.

Factors which may influence a patient’s feedback included:

1) External factors
   How long they had to wait, the décor and environment of the clinical room or the scheduling of the appointment in school holidays versus term-time

2) Diagnosis
   With the possibility of certain diagnostic groups being more likely to provide negative feedback e.g. Eating Disorders, emerging personality disorder

3) Engagement
   Whether a young person felt they needed or wanted to attend the appointment

4) Age
   Adolescents versus children

Benefits

Children and young people were observed to value being asked for their feedback, rather than their parents; some put a lot of thought into which box they posted their counter into. The high rate demonstrated that all patients are able to engage in the scheme, including those with additional needs.

It required little financial or time resources in either setting it up or the ongoing management. Minimal training is required by clinicians and it is a basic administrative task to empty the boxes and record the results on a monthly basis.

The feedback can contribute to service development and also feeds into appraisal and revalidation via personal reflection.

Posters were displayed in the department, near the boxes, which provided data on the previous month’s results (This relates to statement five in the NICE Quality Standard 147).

Limitations

The main limitation was the lack of detailed, qualitative information; doctors wanted to know ‘why’ patients felt an experience had been negative.

Next steps

The project was to be rolled out across the whole multidisciplinary service. Alternative technology and social media were to be explored e.g. incorporating it into the Trust’s mobile phone app or using a touch screen in the waiting room.
ON SEPTEMBER 16TH, there was a special British screening of the 1965 Czech film ‘Long Live the Republic’. Two short clips from the film had featured in the critic and director, Mark Cousins’s recent documentary, ‘A Story of Children and Film’. Mark’s personal and idiosyncratic look at the place of young people in the movies, which featured dozens of films from different countries and time periods, was well received at Cannes in 2013. It had a general art house release in the spring of 2014.

On the back of the film’s success, the British Film Institute decided to screen some of the lesser known and rarely shown films included in the movie.

Earlier this year, ACAMH was contacted by Dr Robin Basu Roy, an academic paediatrician with an interest in cinema, who saw this as an excellent opportunity to increase public engagement with child health issues. Robin had been running a medical film club in Camden for several years and had found that the showing of DVDs to a multidisciplinary group sparked interesting and lively debate. He had arranged screening of six of the films in cinemas in London, each with different themes such as blindness, anthropology, living with disability and education.

He suggested that ACAMH might like to promote the screening and provide an expert for a question and answer session to discuss the impact of war on children’s mental health. Professor Bill Yule kindly agreed to contribute. Professor Peter Hames, an expert in Czech films with a chair in film studies and Dr Gordon Bates, a child psychiatrist with an interest in medical humanities made up the rest of the panel.

The film was shown at the Cinema Museum in Kennington, a beautiful Victorian high Gothic Workhouse which has two screens for private events. Around fifty people from a variety of clinical and nonclinical backgrounds enjoyed the film which is set in Moravia towards the end of the Second World War as the German army retreats and the Red army moves in. It is described as the director Karel Kachyna’s lost masterpiece in which he jumbles reality, memory and fantasy to capture the intensity of childhood in a war zone.

The film is held together by a captivating central performance from the child actor who plays Oldrich, a small but resourceful boy who copes with beatings from his father and the village bullies with fortitude, using a rich imaginary life. He never loses his own humanity while the adults and other children are clearly shown to be corrupted by the opportunities for financial gain that war can provide.

The Q&A included a wide range of topics. Prof Hames explained the unusual provenance of the film: it had been commissioned by the Czech state to celebrate the anniversary of the Russian liberation of Czechoslovakia but showed the Czechs in a very unflattering light.

Prof Yule highlighted the incredible resilience of children: even within a war zone the majority do not develop mental illness. Dr Bates talked about imagination, humour and creativity as protective factors for children in adverse situations. It was a lively and interesting discussion.

The chair, Dr Basu Roy, brought the proceedings to a close with a reminder of the next film to be shown in the season, ‘Crows’, a Polish film about an unloved teenager who kidnaps a younger girl to mother.

**NEXT SCREENING**

**CROWS**

25 NOVEMBER, 7PM

The Foundling Museum,
40 Brunswick Square, London WC1N 1AZ

Followed by a Q&A on the topic of social work.

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**Long Live the Republic**

Dir Karel Kachyna 1965

Set in Moravia towards the end of WWII, Karel Kachyna’s forgotten masterpiece jumbles reality, memory and fantasy to capture the intensity of childhood in a war zone. Oldrich is the runt of his village, beaten by his father, bullied by the other boys. But he has imagination on his side, and a wiry toughness they can’t defeat.
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ACAMH membership is great value for money and offers support to a wide range of professionals working in child and adolescent mental health

Affordable rates for events
Our conferences are renowned for their high level of research and quality of the speakers. There are events to fit everybody’s needs and busy time schedules with half day, evening as well as full day meetings.

Multidisciplinary
From events organised to articles published, we strive to cover all areas of child and adolescent mental health. Our board of trustees is composed of members from a variety of backgrounds: social workers, academics, nurses, psychiatrists and psychologists.

Convenience and accessibility
Thanks to our new redeveloped website we have now an extensive collection of online resources which can be accessed anywhere at any time of the day.

We offer online access to the association’s journals, to 25 other mental health titles selected by Wiley Blackwell, videos, screencasts and slides of past ACAMH events and recently we have started developing a knowledge area with expert guides on mental health topics from specialists eminent in their field.

High quality of material produced
ACAMH publishes two very high quality journals with JCPP in particular internationally recognised as the leading publication covering both child and adolescent psychology and psychiatry. Other material produced includes a series of occasional papers on relevant and topical disorders which also cover approaches and interventions.

Journal of Child Psychology and Psychiatry
Impact Factor: 5.669
ISI JCR: 2/65 (Psychology Developmental) 7/74 (Psychology) 9/124 (Psychiatry – Social Science) 12/135 (Psychiatry)

Child and Adolescent Mental Health
Impact Factor: 0.954
ISI JCR: 78/111 (Psychology Clinical) 88/117 (Paediatrics) 94/124 (Psychiatry – Social Science) 103/135 (Psychiatry)

Also of particular interest is our newly redesigned newsletter, The Bridge, with invited articles, calendar of forthcoming events, reports from our branches and of past conferences and reviews of the latest publications on child and adolescent mental health.

New annual rates for 2015

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Having been cross trained in both strategies and motivated to contribute as bridge builder, I gladly react to the appeal of Masters, who wrote an introductory comparison between Trauma Focused CBT (TF-CBT) and EMDR (Published in The Bridge, 2014, issue 1). I am trained and experienced in both methods as therapist, consultant and trainer. I was also involved in research as coordinator of the trauma centre, where a study took place comparing the effectiveness of both (Diehle et al, submitted). In this article I will comment on Master’s comparison and proceed with a presentation of my viewpoints, based on clinical experience, theoretical stands and knowledge of research data. After reacting to several assumptions and statements of Masters, I will present a couple of similarities and differences between the two methods, as I conceptualise them. These will be followed by a brief description of published research. To conclude I will suggest a few preliminary criteria for determining which method seems preferable in individual cases.

Fortunately we can state that empirical practice has demonstrated the significant value of both methods and clinical practice has shown that both methods are valuable for and appreciated by children and adolescents, suffering from symptoms resulting from traumatic experiences or adverse life events.

I am trained and experienced in both methods as therapist, consultant and trainer. I was also involved in research as coordinator of the trauma centre, where a study took place comparing the effectiveness of both (Diehle et al, submitted). In this article I will comment on Master’s comparison and proceed with a presentation of my viewpoints, based on clinical experience, theoretical stands and knowledge of research data. After reacting to several assumptions and statements of Masters, I will present a couple of similarities and differences between the two methods, as I conceptualise them. These will be followed by a brief description of published research. To conclude I will suggest a few preliminary criteria for determining which method seems preferable in individual cases.

Fortunately we can state that empirical practice has demonstrated the significant value of both methods and clinical practice has shown that both methods are valuable for and appreciated by children and adolescents, suffering from symptoms resulting from traumatic experiences or adverse life events.

Reactions to Masters
Here I take the liberty to correct some of the misconceptions presented by Masters. I shall also discuss the statements I disagree with and react to some questions raised.

Misconceptions

PHASE 2: ….. Can also include teaching and practicing of parenting skills, and child social and safety skills.

In this (or any other) phase neither parents/ caretakers nor children are taught any of these (or other) skills. Characteristic for EMDR is that it is focused on adaptive information processing. Skills training is not part of the protocol.

PHASE 3: Detailed assessment of ……..

The mentioned order is incorrect and incomplete. The selected target image is the start (because that is supposed to be the stimulus), then the negative cognition (because the dysfunctional signification supposedly leads to emotional, physical and behavioural responses), then the positive cognition (i.e. how true does the positive cognition feel on a gut-level, this question gives perspective to the client where the path will lead to, raises the arousal and stimulates the appropriate alternative neuronal networks (Shapiro, 2001)), then the VoC (this gives the therapist a baseline), then the emotions (evoked by target image combined with negative cognition); then the evoked body sensations in terms of level of distress, expressed by SUD’s level; then body location of the distress (where in the body is the distress felt the most).

PHASE 4: When the eye movements and concentration on a memory (for example anger) are neutralized, ……..

Eye movements and concentration of a memory are not neutralized. What is neutralized is negative affective load of the target image and the dysfunctional signification that causes the negative affective load. At the start of phase 4 the target image has a high SUD, because of dysfunctional signification (negative cognition). By the desensitization process the image loses vividness and validity (Shapiro, 2001) until it is neutralized, meaning that the emotional and physical responses to the image are faded and the dysfunctional negative cognition is no longer valid.

PHASE 5: ‘This positive thought is instilled independent of the traumatic memory and then is paired with it’.

This is not correct. The positive cognition is the functional counterpart of the negative cognition and was stated in phase 3. It is related to the target image.

Differences

In TF-CBT, treatments are focused on memories on one hand and on reprocessing of the memory to ‘adaptive resolution’ (Shapiro, 2001)). Differences in procedures can be distinguished on several aspects (Beer & De Roos, 2012):

PROCEDURAL ASPECTS

What is activated: In EMDR all elements of a memory-representation are activated: images, emotions, cognitions and body sensations. In TF-CBT the focus is on the cognitive triangle: behaviour, cognitions, emotions (Cohen et al, 2006). Children do learn to recognize body sensations for the sake of differentiating between emotions.
For reduction of stress in the body several relaxation techniques or distraction techniques are taught.

Who is activated: In TF-CBT both the child and the parents/caretakers are activated and involved in the treatment. Aim is to improve their communication about what happened. It is a system-oriented treatment. In EMDR the child is always involved and parents/caretakers only when and if it seems relevant for the healing process of the child. It is an individual-oriented treatment. In younger children parents do play a more central role, but only in order to facilitate the treatment process of the child.

How is the memory activated: In TF-CBT the anxiety network is activated as much as possible by evoking the memory representation with maximal details and vividness together with associated emotions and signification that took place in the past. In EMDR the memory representation is activated in the assessment phase by directing the focus exclusively to actual signification, emotions and sensations, not to those in the past. During the desensitization phase the therapist leads the child back to the target image (which changes during the desensitization process) at specific moments in the process, just to give a new impulse to optimal continuation of the desensitization process. Some therapists consider this throwback incorrectly as exposure.

How are core cognitions taken care of: Negative core cognitions (for example ‘I am good for nothing’), formed after a multitude of traumatic experiences, are approached in CBT experiential techniques and behaviour experiments. In TF-CBT this type of cognitions is not differentiated nor approached differently from automatic thoughts. In EMDR however they are ‘attacked’ by reprocessing the memories that gave roots to these convictions and reinforced them so they became stronger and stayed alive.

THE PROCESS OF CHANGE

In TF-CBT the child seems to integrate incoming information (psychoeducation and questions from the therapist challenging cognitions) through accommodation and assimilation. In EMDR the process of change seems to go the opposite direction, from the inside out. New insights arise during desensitization within the person, without hardly any input of the therapist. The process unfolds practically without interference. The upcoming information is also integrated through assimilation and accommodation.

RESULTING CHANGES
ON NEUROBIOLOGICAL LEVEL

In exposure procedures it is supposed that extinction of the fear takes place because a new memory is formed, which is incompatible with the original one, and the new one is dominating (Brewin, 2006). In EMDR it is supposed that the traumatic memory is stored with a fresh different signification, leading to elimination of the trauma-related symptoms (Shapiro, 2001). Suzuki et al. (2004) write that experiences are still controversial regarding the question how relevant the length of exposure is for resulting neurobiological processes. ‘Reconsolidation may prove to be the underlining mechanism of EMDR as opposed to extinction caused by prolonged exposure therapies. Memory reconsolidation after retrieval may be used to update or integrate new information into long-term memories. Brief exposure (…) seems to trigger a second wave of memory consolidation (reconsolidation), whereas prolonged exposure leads to the formation of a new memory that competes with the original memory (extinction)’. (p.4791)

SUPPOSED MEDIATING FACTORS

Different mechanisms are supposedly relevant in both methods. In exposure it is assumed that activation of the anxiety-network is essential for integrating new information and extinction of conditioned fear (Foa, Keane & Friedman, 2000). Exposure procedures have a dual purpose: facilitating and effectuating change. The last one may be realised by extinction of fear and/or falsification of catastrophic expectations that arose during or after the event(s), like ‘I am going to die’ or ‘I am a loser’. Therefore exposure to the memory should last during a certain period of time, so that new information can be assimilated completely and new memories can arise during reliving (Grey et al., 2002).

Lee, Taylor & Drummond (2006) however demonstrated that distancing from the memory during the desensitization phase in EMDR is correlated with the reduction of PTSD symptoms, and not reliving. Distancing seems to be provoked by eye movements (Lee & Drummond, 2007). Eye movements and other forms of distraction serve to enable the child to be confronted with the memory in combination with maximal distraction, with the effect that the memory can be stored anew with a different meaning. The hypothesis of the working memory (Gunter & Bodner, 2008; Engelhard et al, 2010) corresponds well to this. This hypothesis says: the working memory is capable of executing different tasks at the same time (like planning a task, retrieval and restoring of a memory), but has a limited attention-capacity. If a child has to concentrate at the same time on a negative memory and on a distracting task, a competition between tasks arises. As a result the memory loses affective load and vividness, if the working memory is taxed sufficiently by the distracting task. This leads to storage of the memory in the long-term memory with a different meaning.

ROLE OF THE THERAPIST

In TF-CBT the therapist plays a crucial role for effectuating change in cognitions. By asking specific questions, having Socratic dialogues and using other cognitive techniques the therapist guides the thinking process of the child. Content, formulation and timing of the questions are essential to make this process happen and move in the right direction. In EMDR the role of the therapist is less important. The therapist only facilitates the child to go with the flow of the self healing process, enables the natural information processing system to continue its – until then blocked –road. When the psychopathology of the child becomes more complex, the role of the therapist becomes more important. He will initiate more interventions (pro)actively to keep the process going and eliminate barriers.

EMOTIONAL BURDEN FOR THERAPIST AND PATIENT

In EMDR the explicit exposure to the memory(representation) lasts a relatively short period, during the assessment phase. During the desensitization the client follows a track of associations. In CBT- programs in general the patient is expected to be exposed to the memory (representation) during a longer period in-session and next to that do homework assignments daily between sessions. This makes the treatment harder to endure and raises the risk of premature drop out of treatment. In TF-CBT however this particular aspect is less prominent compared to other CBT programs, because here the exposure to the traumatic memories takes place only in-session and is not accompanied by homework assignments. The developers of TF-CBT (Cohen, Mannarino & Deblinger, 2012) affirm that ‘Gradual exposure is incorporated into all components. During each subsequent PRACTICE component, the therapist carefully calibrates and increases exposure to trauma reminders’.
Research
Most randomized controlled trials conducted with TF-CBT have taken place on children who have been sexually abused and show large treatment effects compared to a waiting list condition or supportive therapy (Celano et al, 1996; Cohen et al, 2004, 2005; Deblinger et al, 2001; King et al, 2000). TF-CBT appears also effective in children who developed PTSD after a single event (Smith et al, 2007) and in children who experienced or witnessed domestic violence (Cohen et al, 2011; Stein, 2003).
A dismantling study showed that the Trauma narrative module is particularly relevant for overcoming anxiety related to abuse and generalized anxiety. Modules focused on teaching skills to children and parents appear crucial for treatment of externalizing behaviour problems (Deblinger et al, 2011; Cohen et al, 2012).
Two randomized controlled studies have been published comparing EMDR with a form of CBT (Jaherhaderi et al, 2004; De Roos et al, 2011). Jaherhaderi included adolescents who were sexually abused. De Roos et al (2011) included children who had experienced a single event, a fireworks disaster. In both studies EMDR and CBT appeared equally effective, EMDR more cost-effective, because results were established in less therapy time.
Dichle et al (submitted) compared the effects of TF-CBT with EMDR. Results will be known soon. De Roos et al (in preparation) compared in another study the effects of EMDR with those of Cognitive Behavioral Writing Therapy (CBWT), a program whose core component (writing the trauma narrative) shows resemblance with TF-CBT, but that does not have the preparatory PRAC modules nor the module where child and parents (learn to) communicate about the trauma narrative. Also results of this study will be published soon.
Based on research outcome TF-CBT and EMDR are both mentioned in various guidelines as the most promising forms of treatment. According to the guidelines of the National Institute of Clinical Excellence (NICE, 2005) ‘...children with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused cognitive behavioural therapy, adapted appropriately to suit their age, circumstances and level of development. ...Families should be involved in the treatment. Parental involvement alone in unlikely to be of any benefit for PTSD symptoms. ...Parents (and if usefull adolescents) should be informed that there is no empirical evidence for the effectiveness of other forms of treatment, such as play therapy, art therapy or family therapy.’
Randomized controlled trials are recommended ‘...to identify relative efficacy of different trauma-focused interventions and provide information on the differential effects, if any, arising from the age of the child or the nature of the trauma experienced’. (p. 115)
In the Practice Parameters of the American Academy for Child and Adolescent Psychiatrists (AACAP, 2010) TF-CBT is referred to as ‘evidence-based and effective first choice treatment for children with PTSD and comorbid anxiety, depression and other trauma-related symptoms. Regarding the use of combinations of treatments ...... no guidance can be given on the basis of empirical research’.

Preliminary criteria
Based on clinical expertise we can formulate only preliminary criteria, awaiting research data to guide us further.
TF-CBT seems preferable when there is indication for phased treatment, which is not necessarily the case after chronic trauma; when creating order in the disarray within the head and transferring memories into words seems useful; when therapist or child think it is desirable to enable the child to communicate with the parents/caretakers about what happened; when teaching of specific skills seems relevant.
EMDR seems preferable when there is no indication for phased treatment; nor for bringing order in the disarray within the head and transferring memories into words; nor for stimulation of communication between parents/caretakers and child about what happened; nor for the necessity to teach specific skills.
Positive criteria: suffering from recurrent memories by intrusive thoughts, images, nightmares, sleeping problems, hyper arousal, anxieties, specific trauma related fears, dysfunctional core beliefs about the self or other people.

Phased treatment is not always necessary. Direct reprocessing of traumatic memories should start as soon as possible, because symptoms can cause a lot of suffering to the child and its environment, can cause comorbid and chronic psychopathology, and can disturb growth and development (Chentob, Nakshima & Carlson, 2002). The hot debate between trauma-experts about necessity versus nonsense of phased treatment asks for clear criteria when to use it and what the child should learn in the first phase, when a previous one is considered necessary.
Phased treatment should be considered when the traumatic memories are supposedly too painful or scary yet and the child seems unable to be confronted with them, because it lacks skills to adequately cope with reactions to them. Also lack of trust in adults, including the therapist, is a criterion, because it hinders a functional working alliance and therefore enlarges the risk of derailment. Another criterion is lack of awareness that there is a connection between actual symptoms or behaviour and events in their past. The function of a preparatory/stabilisation phase in those cases is to build a bridge between this initial state and the necessary state for successful trauma treatment. By interventions in this preparatory phase the attitude of the child should change; it should learn relevant skills and regain trust in adults and him/herself, so that successful reprocessing can follow in the next phase, without the risk of premature drop out of treatment. The knowledge of the child should be completed so that it can see that there is a connection between his/her behaviour and specific memories. The PRAC modules seem to meet these criteria.

Conclusion
Masters deserves respect for taking the initiative to formulate her ideas about this important issue. We share the conviction that we are dealing here with two most valuable methods for treatment of children and adolescents with trauma-related psychopathology, two of a kind. Hopefully research data combined with findings from clinical practice will reveal criteria in the near future that help us decide which treatment is the best for which child for what reason.
ACAMH invites reviews for publication in JCPP or CAMH or on the website, of newly received books and publications. Being a reviewer is a good way to become involved with ACAMH, to share key updates and useful information and to potentially get your name published and raise your profile.

To become involved, please contact carole.sutherland@acamh.org

ADHD in preschool children: assessment and treatment

JK Ghuman and HS Ghuman (Eds)
Oxford: Oxford University Press, 2014
pp. 228, £29.99 (pb)

**THIS BOOK IS** a timely and welcome addition for those clinicians involved in the assessment and treatment of ADHD in children. It is a comprehensive, ably edited and well referenced book that is written by American and Canadian researchers, clinicians and experts in the field of ADHD. It has relevance for UK and European clinicians and cites European and UK guidelines and research.

The origins of attachment: infant research and adult treatment

B Beebe and FM Lachmann
Hove: Routledge, 2014
pp. 256, £29.99 (pb)

The 10 chapters are divided into two sections. The first provides a detailed enquiry into the evaluation and assessment of ADHD in preschool children and the second section focuses on treatment interventions with an emphasis that guidelines support use of psychosocial and behavioural management strategies in the first instance over psychopharmacological interventions.

The authors directly acknowledge that the continuing controversy in some quarters regarding ADHD still abounds despite evidence of its diagnostic validity. They recognise that the assessment and treatment of ADHD in preschoolers is even more contentious as some are concerned that normal developmentally expected behaviour of preschool children may be wrongly labelled as ADHD.

In my estimation the authors manage to present a strong case that with careful assessment using multiple informants, and with the aid of reliable, valid and developmentally appropriate rating scales and interviews, that ADHD can be diagnosed and should be treated in the preschool population. They highlight that not identifying and treating ADHD early can result in deleterious consequences for children’s academic, social, emotional and family life. I found this book informative, balanced, and a useful addition for those clinicians who like me are more frequently being asked to assess children under the age of five.

LISA BURKE, SOUTH LONDON AND MAUDSLEY NHS FOUNDATION TRUST

The origins of attachment is highly recommended for students, trainees and all professionals involved in relational interventions.

AMIRIAM LANDOR, EDUCATIONAL PSYCHOLOGIST, EDINBURGH
Anorexia nervosa: a recovery guide for sufferers, families and friends

J Treasure and J Alexander
London: Routledge, 2013
pp.192, £16.99 (pb)

Given the title includes the words ‘recovery’, ‘anorexia nervosa’, ‘family’ and ‘guide’, we expected a greater reflection of recent advances in recovery. This is an interesting point, and perhaps useful at times, it does not acknowledge the potentially damaging effect of this on the sufferers’ recovery, and we wondered if this approach would ever be suggested in the case of ‘cancer’ or ‘heart disease’.

Although this book is confusing and contradictory in places, overall it could be a helpful place to start, given the information included and its commitment to aiding reflection and understanding in the sufferer and the care network. We were, however, disappointed at the missed opportunity to reflect current advances in recovery and new approaches and understanding.

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