The Newsletter

Child and Adolescent Faculty and Executive Issue 40 Autumn 2010

In this issue…

We have updates from the Executive in The Chair's report from Margaret Murphy…a report from the finance officer…and information from the Chair of CAPFECC. We also have updates about CAMHS in Wales and Scotland from the Chairs of the relevant divisions.

We have the winning medical student essay from Lauren Barnfield….and we keep you posted on the "Time to Change" Campaign. There is also a report on a recent conference in Nigeria.

Kay Harvey, The Editor

The Chair's Column

Margaret Murphy

Dear Colleagues

As I write this we are entering another time of change in the NHS across the UK. It can be difficult to assimilate all of the changes in policy which are happening and to anticipate the likely impact on the system we work in. A key aim of the College is to try to influence and shape policy to the advantage of our service users and their families/ carers as well as improving our services.

On a positive note there are indications that the Government has recognized the importance of a good start in life and the need for effective intervention for children and young people who have mental health problems. It is hoped that this recognition will inform the new Mental Health Strategy, which is due out soon. The Government also announced new monies to extend the Improving Access to Psychological Therapies programme across the age range and to people with severe mental illness. The College has played a key role in lobbying for both of these changes. We are working with the British Psychological Society and others on potential models for the CAMHS IAPT and so there is an opportunity to shape implementation.

Despite these optimistic developments I am aware many of us may currently face uncertainty within our services particularly in relation to funding and resources. The Regional Representative network are interested in hearing about reductions in funding or services.

The Coalition Government has already published its plans to reform NHS commissioning in England. The College has worked with the Royal College of General Practitioners and National Mental Health Development Unit to look at the implications for mental health and to develop a guide for mental health commissioning. The details of this work as well as the College response to the White paper on NHS reforms are available on the College website (worth a read especially if you are a higher trainee just about to have a job interview!)

As well as a move to GP led commissioning there are also plans to extend Payment by Results (PbR) to CAMHS. There was a useful workshop at the Faculty meeting in October with presentations by colleagues from London and The West Midlands who have been working on CAMHS PbR. Faculty members are engaged in working with the Department of Health on PbR to try to ensure it is implemented in a way that brings advantages to CAMHS in ensuring a focus on quality and effectiveness rather than simply on cost.

I apologize to colleagues from elsewhere in the UK for the England - centric view thus far. Although the changes in funding structures are unique to England other initiatives such as a focus on quality and outcomes are similar across the UK.

A key element in the reforms is a greater focus on outcomes - in CAMHS many services are already members of CORC or QINMAC/ QNIC and so this isn't all new. The Faculty are working with others including CORC and the BPS to try to develop outcomes in ways

that are meaningful for the individual child or young person and their parents as well as the clinician. The hope is that outcome measures should enhance care rather than simply be another form to fill in or must do. We would be interested to hear about your experiences in using outcome measures in clinical work and whether any of you like the use of patient outcomes for supervision of colleagues.

The transition from CAMHS to Adult Mental Health Services is another UK wide issue. In September we held a joint seminar with Young Minds to discuss the issue. We would be interested in hearing about any examples of good practice and services you feel work. I am aware that in some areas services for children and adolescents may be separate and again we would be interested to hear of your experiences and of any formal evaluations you are able to share.

Our focus hasn't all been on the UK. In October five of us (myself, Clare Lamb, Ama Addo, Anna Maria Deszery and Dickon Bevington) travelled to Nigeria to teach on a course on child and adolescent mental health run jointly with local members of the West African College of Physicians. The funding for our flights came from the College volunteer fund raised by Professor Sheila Hollins (and not from Faculty funds much to the delight of our Finance Officer). Ama has described our experiences in her article. For me the experience was both enlivening and humbling and a useful anti-dote to current concerns.

Finally I would like to thank all of the Executive Members who have worked hard throughout the year.

I would also like to remind all of you that (to paraphrase Lord Kitchener)

YOUR FACULTY NEEDS YOU!!

There will be vacancies on the Executive for Vice-Chair and members. The nominations close at the January Institute. Being on the Executive does bring with it an opportunity to influence not only how the College works but to push for the development of CAMHS and you get to work with enthusiastic and interesting colleagues.

Margaret Murphy
Chair of Child and Adolescent Faculty
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Finance Officers Report

Tony James

I suspect everyone is fed up with financial statements at this time; however, I am glad to report the financial position of Faculty is a little more stable. We will be on line to achieve our target of a financial baseline of at least £30000, or two year's administrative costs. We have reduced expenditure on projects at the moment, but further work needs to be done on reducing administration costs which we hope to tackle in the next year or so.

I am glad to report that the residential conference in Oxford was an outstanding success academically and to a degree financially. As you know the Winter Institutes and the Residential meetings are our only sources of income. This year we decided to reduce the cost of the residential meeting substantially including accommodation to attract more members to the meeting, and in that sense we were successful with over 310 attendees in all. We can not give the financial breakdown at the moment, but the cost of hiring St Catherine's College, an excellent venue was extremely reasonable.

It seems that from the feedback members enjoyed the academic content, speakers particularly Prof Rutter and Prof Scott, and the debate on Paediatric bipolar disorder. The venue was regarded highly and a high proportion of the delegates commented on the value for money.

I can not guarantee to be able to repeat such a good offer, but I will endeavour to keep down prices so that the annual conference will be affordable and within study leave budgets.

The conference venue is to be decided shortly but it is likely to be Cambridge. There is a Winter Institute too (Jan 21st 2010, London) with the Eating Disorder Section which promises to be highly informative and again I invite you to attend this.

The Faculty has decided that the main thrust for Faculty funding will be to support teaching by allowing the academic secretary to attract speakers including international speakers to the residential conference. A further aim is to support training via CAPFEC, for instance supporting the meetings for programme directors. We will also endeavour, as far as possible, to reduce the costs for higher trainees to attend the residential meeting.

Overall, I am hoping that within the next year and year two, by having a clear financial strategy, we will achieve a stable financial position. In the meantime if you have a project that you feel needs funding can you please address that to myself so that it can be discussed at the executive meetings. One off requests which do not meet the Faculty's aims are not likely to be supported, however.

Dr A.C James
Finance Officer
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CAPFECC report

Brian Jacobs, Chair of CAPFECC

2010 is rapidly fading. This year has been a time of less frenetic activity. In the early months we made revisions to the curriculum to respond to feedback from various training programme directors. This has resulted in PMETB (now absorbed in the GMC) allowing us to indicate that certain of the higher training competencies are mandatory for all trainees whilst others are optional but trainees have to acquire a defined proportion of the competencies (80% of ST4-5 competencies and 70% of ST6 competencies) overall. We have also made the research competency more explicit and made provision for the less

academically interested ST trainees to use their research time, once the basic research competency has been achieved, for other training options if agreed with their training programme director. This will allow more flexibility in higher training so that those with a bent for therapeutic training can pursue it and those who want to focus on management can also do so.

We held a very successful training programme directors day in June 2010 which was kindly hosted by Mary Wheatcroft in Derby. Drs Mike Shaw and Sunanda Ghosh presented a survey they had carried out for CAPFECC on trainee and trainer experience of the curriculum after about 18 months experience of using it. This was both informative and encouraging. It indicated some areas in which the curriculum will benefit from further development but for the most part it seems to be doing what it says on the tin. Our impression is that trainees are getting to grips with the curriculum faster than trainers and that they are using it to help ensure that they get the range and depth of experiences that they need from training. They are finding it a useful way to spot the gaps. The same areas of difficulty in getting experience in certain areas of our subject, such as substance misuse and learning difficulties that we knew about from CAPSAC training scheme visits are still reflected as a challenge to achieve in the curriculum feedback.

We have appointed three new members to CAPFECC, Drs Chris Bools, Helen Bruce and Mary Evans and say goodbye to Prof. Chris Hollis, Drs Sharafat Hussein and Dr KA Mirza. This was the first time that CAPFECC has held a formal appointment committee and we were very pleased with the strength of the candidates who applied. We were also able to involve a member of Young Minds in this process. This, we hope, represents the beginning of joint work as we want to include a clear consumer voice in the further development of our curriculum for the future. We are in negotiation with Young Minds about this project. Our next meeting of the committee is on 6th December so that if you have any matters you want us to consider, please contact me.

I am also sitting on the College revalidation committee representing CAPFECC and will keep a watchful eye on these matters also as they apply to Child and Adolescent Psychiatrists. If you have particular issues in relation to revalidation, again early warning of them would be helpful. For the present, the main thing is to ensure that you are keeping up with annual appraisal and that you are discussing locally how you will make arrangements for CPD, for case discussions with peers (two per year, ie 10 over 5 year cycle) and also how you are going to fulfil the requirements of multisource feedback, patient feedback (one of each in a five year cycle) and audits

'It will be expected that each psychiatrist will provide an audit over a 5 year cycle in at least two significant clinical areas of their practice with standards, based on best practice guidelines, re-audit and evidence of both discussion in appraisal and appropriate action. It is important that the audit presented reflects the care provided by the individual doctor and focuses on key clinical practice.' The requirements are all set out in a paper on the College website.

Last but by no means least we have awarded the 2010 Medical Student Prize to Dr Lauren Barnfield of Bristol University Medical School for her essay 'The biopsychosocial approach to medicine as it applies to adolescent addiction'. It was an excellent essay that I would have been pleased to have written myself. She wins a prize of £500 and an invitation bursary towards attending the 2011 faculty residential conference. The essay is printed in this Newsletter, so you can judge its quality for yourselves.

Brian Jacobs
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Please update your details…..

Sara Walker, Chair of Regional Representatives

To ensure good communication between the faculty executive and the membership the regional representatives are dependent upon member's contact details being up to date. Data protection prevents the college from releasing this information so could I please ask each and everyone of you to contact your regional representative with up to date information preferably email addresses. Please do not assume that because you have been in post for many years that we know about you!

In turn I am dependent on the out going representative to inform me about a change in their region, so I apologise in advance if there are any errors in the list below which was updated in June.

Dr Sara Walker
Chair of the Regional Representatives
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Report from the Chair of the Section of Child and Adolescent Psychiatry, Welsh Division

Alka Ahuja

The Welsh Division of the Royal College of Psychiatrists jointly hosted the Celtic Divisions Meeting with the Welsh Psychiatric Society at Cardiff on the 7th and 8th of October 2010. Colleagues from Scotland and Northern Ireland actively contributed and The Irish College of Psychiatrists and Colleagues from Brittany were also involved. The Welsh Psychiatric Society celebrated its 50th Anniversary within the event.

This was marked by a banquet at Cardiff Castle on the 6th of October. A reception was hosted by Ms Edwina Hart, MBE AM Minister for Health and Social Services on the 7th of October which was well attended. The Welsh Psychiatric Society Inaugural Ernest Jones Lecture was presented by Lady Brenda Maddox followed by the Celtic Divisions Dinner at the St David's Hotel and Spa, Cardiff Bay. Professor Dinesh Bhugra, President, RCPsych, Professor Bruno Millet, Head, Dept of Psychiatry, Guillaume Regnier Hospital, Rennes, France and Dr Justin Brophy, President, College of Psychiatry of Ireland attended the ministerial reception and dinner.

The highlights of the first day included the Celtic launch of the College Report 'Risk of Suicide and Self Harm' and the afternoon sessions included parallel workshops on "Training Tomorrow's Psychiatrists" and Psychopharmacology. The second day focused on high quality new research presentations followed by a session held by the hosted by MRC Centre for Neuropsychiatric Genetics and Genomics.

Alka Ahuja,Honorary Secretary, and Clare Lamb, Chair of Faculty of Child and Adolescent Psychiatry, Welsh Division
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Report from the Chair of the Section of Child and Adolescent Psychiatry, Scottish Division

Kathy Leighton

Since the last issue of the newsletter the Child and Adolescent Section Executive of the Royal College of Psychiatrists Scotland have held two further meetings in June and August 2010.

Current Issues Affecting this Specialty in Scotland

Progress has been made towards delivering the changes required to implement the Child and Adolescent Mental Health Services Framework for Promotion, Prevention and Care by 2015. Early Years and Early Intervention remain priority areas and there has been development across Scotland in Infant Mental Health, Primary Mental Health work, The Mental Health of Looked After and Accommodated Children and the Mental Health Provision for Children and Families in Crisis. There is an ongoing National Review of Inpatient Services and Development of Managed Clinical Networks to support Tier 4 Services. National Quality Indicators and Standards are being developed to ensure best practice and the highest quality of care.

Early Years
The Early Years Framework launched in December 2008 continues to be supported by Scottish Government. NHS Education for Scotland has been commissioned to promote parenting training and a training framework is currently being developed. A pilot of family nurse partnerships is underway in Edinburgh.

Access to Specialist Child and Adolescent Mental Health Services
Scottish Government has introduced a HEAT Target for Referral to Treatment as of April 2010. The target is incremental and has been set at 52 weeks for the first year moving to 26 weeks from April 2011. This will allow Health Boards to develop systems to gather information and work with local teams to building capacity and address service needs associated with reducing waiting lists. Meeting the demands of the HEAT Target will be challenging and will involve service redesign and careful use of new resources.

Training and Recruitment in Child and Adolescent Psychiatry
Recruitment to our Specialty has been good and one additional Scottish National training number in Child and Adolescent Psychiatry was provided in the last recruitment round.

NHS Quality Improvement Scotland
NHS Quality Improvement Scotland (NHS QIS) has continued its commitment to the Child and Adolescent Mental Health Agenda following the appointment of a Specialty Medical Advisor in 2008. A 3 year Mental Health Strategy has been developed. Work has progressed over the past year developing a generic child and adolescent mental health integrated care pathway. Standards within this ICP are seen as quality indicators for our specialty and this work is shortly to be released for consultation nationally.

Redesign of CAMHS Workforce
NHS Education for Scotland is leading on training frameworks for multi-disciplinary child and adolescent mental health clinicians to promote good practice and provide training for an expanding CAMHS workforce. This is supported by a multi-disciplinary multi-agency Scottish Steering Group and a UK Expert Reference Group.

Research and Evidence Base
There continues to be concern about the lack of development in Academic Child and Adolescent Psychiatry within Scotland. There was recent good news about the appointment of Professor Chris Gillberg as a part time professor in Child and Adolescent Psychiatry with the University of Glasgow. It is proving increasingly challenging for NHS Consultants to commit time to research particularly with the change in consultant contract to 9:1, DCC: SPA for new appointments with consequent reduced availability of consultants to undertake supporting professional activities including research.

Academic Secretary's Report

The Child and Adolescent Section Academic Meeting will be held on 26 November 2010 in St Mungo's Museum, Glasgow. The topic is the Impact of Addictions in CAMHS.
A joint meeting is planned with the Learning Disability Section of the Royal College of Psychiatrist Scotland for Autumn 2011.

A successful two day event was held on Forensic CAMHS on 16/17 September 2010. This was primarily aimed at Higher Trainees but Consultants from the Child and Adolescent Section and Forensic Section were also in attendance.

Communication with Royal College of Psychiatry Members
Our section now has a page on the Scottish Division website, Royal College of Psychiatrists, Scotland Minutes for our Executive meetings are posted and information about forthcoming events. The Annual General Meeting of the Scottish Child and Adolescent Section will be held at St Mungo's Museum, Glasgow on 26 November 2010 at 11.15 a.m. Graham Monteith, Scottish Government CAMHS Nurse Advisor will be in attendance and will give a presentation on CAMHS.

There will also be elections for new members of the Executive. Nomination Forms are available on the website or from myself or the Section Secretary Anne McFadyen, email: Anne.McFadyen@nhs.net

Dr Kathy Leighton (email: Kathy.Leighton@renver-pct.scot.nhs.uk or
(sec) Janette.Egan@renver-pct.scot.nhs.uk)
Chair of Child and Adolescent Section

Royal College of Psychiatrists, Scotland

Intensive Child & Adolescent Mental Health Training Course in Nigeria

Dr Ama Addo

When a Memorandum of Understanding was signed between the Royal College of Psychiatrists and the West African College of Physicians in June 2008, one of the objectives was "To participate in each other's educational and other related programmes". An early proposal was for a One-week Intensive Training Course in Child and Adolescent Mental Health which was held in October 2010 in the University College Hospital, Ibadan, Nigeria. UK Psychiatrists Ama Addo, Dickon Bevington, Anna-Maria Deszery, Claire Lamb & Margaret Murphy joined West African College consultants Ikeoluwa Lagunju, Oluwayemi Ogun, Michael Olatawura & Olayinka Omigbodun to provide teaching by didactic lectures, case discussion, smaller group discussion and 1-1 question & answer sessions.

With the exception of one intrepid Psychiatry Trainee from Kenya, all the delegates were from Nigeria, a country of 140 million people, 44% of whom are aged under 15 years, in 250 recognised different ethnic groups. A number of delegates had to travel for more than 10 hours to attend and some had come from areas of recent civil unrest. The majority were Psychiatry consultants and trainees however the 66-strong group included Primary Care Physicians, Nurses Therapists, Psychologists, Paediatricians and Social Workers all with wide ranging and extensive experiences in mental health services.

The 5-day programme, which had been agreed between local & UK organisers, started at 8.30am and continued until after 5pm. Sessions included those on clinical disorders and therapeutic interventions. The long days were made easier by the enthusiasm of those attending and their active participation. People actually volunteered for role-play!

The most enjoyable sessions were those shared by West African & UK Tutors which revealed a great deal of commonality. However, some of the liveliest discussions explored how mental health professionals engaged patients and their families in mental health interventions, when they held strong traditional & religious beliefs in spirits, witch-craft & demonic possession. The importance of religious beliefs was confirmed when a talk on Child Protection Legislation in Nigeria included 3 verses from the Old Testament Book of Proverbs which supported the use of corporal punishment in child-rearing. The English translations for the local language biblical verses were found on the mobile telephone 'bible app' of a delegate.

It became apparent that there was even more stigma associated with mental health disorders and Epilepsy in Nigeria than occurs in the UK. The relatively high rates of infant death, road traffic accidents, child labour, as well as the reduced access to education and their impact on child & adolescent mental health were also explored. Epidemiological studies in Nigeria, show similar prevalence rates of mental health disorder in the child and adolescent population to those in the UK. Delegates discussed running clinics with more than 80 patients attending, having to decide on interventions depending on the ability of families to be able to sustain paying for them and sometimes having a sudden absence of certain medication when imported supplies were exhausted.

Faculty colleagues were discouraged from going out alone in the evening because of the potential risk of crime. It was hard to uncover whether this was a perceived or actual risk but at least one delegate related that a medical colleague had been kidnapped and held for ransom in recent weeks. The commitment of mental health professionals to work in such difficult circumstances was both inspiring & humbling.

At present there have been 3 proposed outcomes from the course:

- The development of a monthly joint clinical/service development meeting between a Child & Adolescent Consultant Psychiatrist & a Consultant in Paediatric Neurology.
- The development of an Adolescent Psychiatry clinic with a Primary Care Physician who runs an adolescent health clinic.
- 3 Psychiatry Higher Trainees intend to develop a child & adolescent mental health training programme for staff in the Juvenile Justice System.

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An Update on the "Time to Change" campaign

Time to Change is England's biggest campaign to end the stigma and discrimination that people with mental health problems face. Run by the leading mental health charities Mind and Rethink, and funded by the Big Lottery Fund and Comic Relief, the programme is proven to be having a positive impact on public attitudes and, crucially, behaviours towards people with mental health problems.

Nine out of 10 people with mental health problems say they face discrimination in some area of their lives – and for some, the stigma that comes with a mental illness can be worse than the illness itself. Many people identify stigma and discrimination as the biggest barriers to wellbeing, recovery and quality of life.

That's what Time to Change is here to tackle. Since January 2009, we have been running a high-profile national advertising and media campaign, backed up by community events, individual activists, and targeted work with key professional audiences, to change public attitudes towards mental illness and encourage people to realise that it's the assumptions we make about people with mental health problems that hurt the most.

The campaign has support from some famous figures who have been through mental health problems themselves – like Frank Bruno, Stephen Fry, Ruby Wax and Alastair Campbell. Celebrities speaking out have a powerful impact, helping get the message across that mental health problems can happen to anyone, people can and do recover, and it's OK to talk about it.

Frank Bruno, who had a very public breakdown in 2004 and has since been diagnosed with bipolar disorder, says:
"One in four people will have some kind of mental health problem. It can happen to anyone; milkmen, lawyers, even boxers."

And Stephen Fry, who also has bipolar disorder, has said:
"I want to speak out, to fight the public stigma and to give a clearer picture of mental illness that most people know little about. Once the understanding is there, we can all stand up and not be ashamed of ourselves, then it makes the rest of the population realise that we are just like them but with something extra."

Much of Time to Change's work is based on the social contact theory, which shows that one of the most powerful ways of breaking down negative attitudes is bringing people with and without mental health problems together. Our community events do this, and we support individuals with mental health problems to speak out and challenge discrimination for themselves. We also provide training, delivered by people who have experienced mental health problems.

We now have evidence that our work is beginning to have an impact. The Institute of Psychiatry, King's College London, is evaluating all our work and the latest results show that since the launch of the campaign there has been a significant 1.3% improvement in public attitudes. And more importantly, people with mental health problems living in the community are reporting lower levels of discrimination (according to our survey of 1000 people on the Care Programme Approach in different areas of England, discrimination dropped by 4% between 2008 and 2009).

Time to Change is currently funded to run until September 2011, and we have just launched our latest campaign, 'Don't get me wrong', which highlights the discrimination people face when dating and looking for somewhere to live. The campaign is based on a unique social experiment in which seven volunteers placed ads on leading dating and flatshare websites. First they placed the ads without mentioning their mental health problem. Then, they placed the same ads with one line added: 'I have a mental health problem.' There was a big drop in interest – overall, letting people know they have a mental health problem meant our volunteers received 50% fewer responses to their dating ads and 68% fewer responses to their flatshare ads.

These results have been used in advertising and PR to encourage the public to think about their own attitudes. One of our volunteers, Erik, has featured in a short film about his experiences, which you can watch online at www.time-to-change.org.uk/erik.

We're also asking people to pledge their support to the campaign, and to do something small in their own lives that will make a difference to people with mental health problems. Make your pledge online at www.time-to-change.org.uk.

CAMHS to AMHS Transition Day

Presented by QINMAC

A transitions day was held by Quality Improvement Network for Multi-Agency CAMHS (QINMAC) for staff working in Tier 2 and 3 Child and Adolescent Mental Health Services (CAMHS) across the UK. The day was chaired by Carol-Anne Murphy (Nurse Consultant in Transitions, Five Boroughs Partnership NHS Trust).

The day provided an opportunity for staff working in Tiers 2 and 3 to discuss current protocol regarding the transition of young people from CAMHS to Adult Mental Health Services (AMHS), and to examine the problems that services face at present. The day incorporated presentations from members of Tier 2 and 3 services, who spoke about protocols their own services have in place regarding transitions, the results from recent audits and what these imply. Two young people from the Very Important Kids (VIK) panel also attended the day, and spoke about their own experience of transition. The young people provided a valuable insight into how they believe services can improve the way in which transitions are dealt with, and offered useful ideas for improvement from the perspective of a service user.

Current problems identified regarding the transition from CAMHS to AMHS
Numerous problems were identified as key to overcome in order to further develop and improve the way transitions are dealt with. The main issues include:

- *Age of Transition*; It was evident from discussions throughout the day that there is a disparity between services in terms of the age that transition takes place. Some Trusts transferred young people to AMHS at the age of 16 years, whereas others would not begin the transition process until 6 months before their 17th or 18th birthday, or later in some cases. In other Trusts, the age of transition depended on whether the young person was in full time education, which was found to complicate matters further.

- *Protocol*; As above, where protocols are in place, these are not consistent between Trusts. This was found to cause confusion for young people and their parents/carers, as what may have been the protocol in one trust may be entirely different in a different trust.

- *Lack of Communication*; Staff spoke about the lack of communication between CAMHS and AMHS, and the need for greater knowledge and understanding of AMHS for CAMHS workers, and vice versa. Staff felt that if they were more knowledgeable about each service, the transition between services would be smoother, and both staff and young people would know what to expect when the transition process begins.

- *Service User Involvement*; The young people who presented on the day highlighted that the transition process can be a very daunting experience, and spoke about how they felt their views were often overlooked. The need to involve service users in their own transition was emphasized, and the lack of comprehensive information available to service users regarding transition to AMHS was also identified as a problem.

Next Steps for Transitions

During an end of day discussion, guests were asked to identify the next steps for transitions, and what changes they would like to see in the near future. Some of the main points identified are listed below:

- *Develop Transition Standards which are Consistent across Services;*
  - The need to develop a national transition protocol was identified numerous times throughout the day. This would make transitions more consistent and avoid confusion and frustration for young people and their parents/carers.
  - However, emphasis was put on the need for services to be flexible regarding the age of transition. Services need to consider a young person's needs and developmental age, rather than purely chronological age.
  - QINMAC to review services and develop transition standards (including standards for commissioning). To be reviewed this year.

- *Improving Communication/Relationship between CAMHS and AMHS;*
  - This could be achieved through CAMHS working creatively with AMHS, and vice versa. This may include joint presentations and joint training days within each service, providing an opportunity for staff to learn more about the other service, and what the young person can expect.
  - Also discussed was the introduction of a link nurse for transitions (in both CAMHS and AMHS), who will have more in-depth knowledge regarding transitions, so if staff or young people have any queries they know who to approach.
  - Stronger links should be developed with AMHS, and CAMHS should involve them in what is happening i.e. provide information on Young Minds, VIK etc.
  - Transition meetings were also discussed, through which representatives from both CAMHS and AMHS join to plan a young person's transition. The young person would also be involved in this, and it would provide an opportunity for joint assessments in order to avoid multiple assessments
  - The idea of a secondment/rotation of CAMHS workers to AMHS (or vice versa) was also discussed, to give a greater insight into what to expect from a service following transition, and will help to overcome the "fear of the unknown".
  - The young people from the VIK panel spoke about how they would have found an advocate for transitions very useful and supportive. The young people said that the advocate would preferably be separate from both CAMHS and AMHS, and perhaps would have gone through the transition themselves, where they are able to speak from experience. Where this is not possible, a representative from AMHS would be preferable to CAMHS, in order to gain greater insight and feel more involved in AMH services. The advocate would be able to inform the young person about what to expect, and would be a familiar face for the young person following transition.

- *Involving Service Users in their Transition*
  - It was agreed that it was very important for young people to be routinely involved in the planning of their own transition, and to be kept informed throughout the process.

- Services need to introduce better systems for young people to feedback thoughts, ideas, experiences etc., and to also put systems in place to act on this feedback.
- When developing protocols/standards for the transition process, young people's views need to be taken into account, and incorporated into protocol. The use of feedback sheets and seeking opinions from Young Minds, VIK panel etc. should be considered.
- Services need to look at developing resources for young people who are transitioning in order to provide them with information about the transition process. These resources may include websites, information packs, discharge packs, and welcome packs upon entering AMHS, that services have a duty to provide

- Furthermore, it was mentioned that all staff and services can learn from good practice. It was emphasised that attention needs to be drawn to good examples of transitions, and that this should be recognised and rewarded.

IACAPAP and the IACAPAP book series

IACAPAP (International Association of Child and Adolescent Psychiatry and Allied Disciplines) is an organisation that aims to promote the study, treatment, care and prevention of mental and emotional disorders and problems of children, adolescents and their families. The emphasis is on practice and research through effective collaboration among professionals from child psychiatry, psychology, social work, paediatrics, public health, nursing, education, social sciences and other relevant professions. Its membership is constituted of national associations.

IACAPAP organises training, dissemination and advocacy meetings in different regions of the world. It also organises international congresses. These are highly successful in terms of attendance, scientific contributions and opportunities for delegates to acquaint themselves with practice by CAMHS professionals across different continents.

Alongside each Congress IACAPAP edits a scientific book: these books are unique by virtue of their consistent emphasis on issues that have broad, worldwide significance.
ACAMH members interested can obtain the books for the last 3 Congresses (Melbourne 2006, Istanbul 2008 and Beijing 2010) from the publishers http://www.rowmanlittlefield.com/Catalog/

THE IACAPAP BOOK SERIES 2006- 2010

Increasing Awareness of Child and Adolescent Mental Health
Edited by M. Elena Garralda and Jean-Philippe Raynaud

Culture and Conflict in Child and Adolescent Mental Health
Edited by M. Elena Garralda and Jean-Philippe Raynaud

Working with Children and Adolescents: An Evidence-Based Approach to Risk and Resilience Edited by Elena Garralda and Martine Flament

The Winning Medical Student Essay

The Biopsychosocial Approach to Medicine as it applies to Adolescent Addiction

Lauren Barnfield

Introduction

The biopsychosocial model was developed in 1977 by George Engel as a much-needed alternative to the prevailing purely biomedical model of the time. Ten years later, Donovan and Marlatt applied this model to addiction. They concluded that if an individual's addictive behaviour could be assessed in the context of their psychological state and social environment, treatment could take this into account, and outcomes would be greatly improved. Recent scientific advances have shown there to be several different risk factors for addiction and relapse. These include genetic predisposition to addiction as well as premorbid personality traits, past trauma, psychiatric or medical co-morbidities and a stressful home environment. Combined, these highlight the importance of a well-rounded model when considering treatment for addiction. Nowadays, rehabilitation for substance abuse usually encompasses the physical process (detoxification) and psychological treatment (counselling, CBT, group therapy) whilst emphasising social reintegration. Addiction medicine is almost unique in that the biopsychosocial model is universally used as a vital tool for both assessment and treatment.

Adolescent drug and alcohol-seeking behaviour is already rife in the UK and developed world, and the number of adolescents seeking help for addiction to these substances is rapidly rising. It is an undeniable fact that the well-documented biopsychosocial model for addiction must be adapted when considering the needs of children and adolescents, whose bodies and brains are still changing and very vulnerable to injury, and who may be especially susceptible to the influences of their peer group.

I recently gave a presentation on this fascinating and relevant topic for my psychiatry student-selected component (SSC). In order to research in greater depth what resources are provided by mental health services for these young people and how they are used, I spent the day with a specialist adolescent drug treatment unit in the South West, where I met several service users. In this essay I will outline the epidemiology of adolescent addiction, explore the risk factors and causes from an evidence-based biopsychosocial approach and use a case study from my experience to illustrate the ways in which this model can be effectively used to treat and prevent relapse in adolescent addicts.

Epidemiology of Adolescent Addiction

Adolescent substance addiction has received a lot of interest recently in the scientific community as the subject of a number of journal articles, books and even conferences (eg. MA Healthcare 3rd National Conference: Child and Adolescent Addiction). The many ways in which addicted adolescents differ from adults include the reasons for and theories

behind substance abuse, the substances abused, the time frame and consequences of addiction (table 1).

Table 1: Some of the differences between adolescent and adult addictions (adapted from Gust and Smith, 1994)

Adolescents	Adults
6-18 month progression	5-10 year progression
Mostly psychological dependence	Tolerance/withdrawal
Glorification of use	Minimisation of use
'Garbage can' syndrome – any chemicals	Often a single chemical of choice
Social activities often *are* chemical use	Social activities often include chemical use

Adolescents receive mixed messages about alcohol and drug use. In the tabloid newspapers, teenage drug users are portrayed as criminals and wasters, both a cause and a consequence of 'broken Britain'. However, TV programmes and films aimed at adolescents tell a very different story. *Skins*, for example, a programme written by young adults about and for teenagers, portrays casual and regular drug use with no negative consequences, and certainly no mention of addiction. Consequently, to the young people watching, alcohol and drugs become exciting and rebellious; adults who disapprove are boring and dictatorial. This media portrayal combined with the easy availability of illegal substances may lead adolescents to see experimentation with substance use as a rite-of-passage. A 2009 Drink aware survey found the median age at which adolescents have their first alcoholic drink to be 13.4 years, with an average age at first being 'drunk' of 14.2 years. Similarly, by the age of 15, 41% of pupils surveyed in 2007 reported having tried illegal drugs at least once (NHS Statistics on Drug Misuse, 2008).

It is worth noting that, possibly as a result of national campaigns such as 'Talk to FRANK' as well as improved school education, overall alcohol and drug use in the 11 to 15 year olds surveyed *has* declined significantly between 2001 and 2008 (NHS Statistics on Drug Misuse, 2008). There is no way to assess whether the true number of adolescent addicts is similarly declining, but a greatly increasing number of under-18s are seeking specialist treatment (figure 2). This may be due to an increase in availability or better advertising of services provided by mental health trusts, along with improvements in screening for substance misuse problems.

It is difficult to obtain accurate statistics on addiction. The DSM-IV categorises substance use disorders into the categories of abuse and dependence (abuse is the milder, and it may progress to dependence). Some studies argue that the similarity between the substance abuse and dependence categories shows that a more accurate system for research would classify severity by overall symptom count, rather than using the binary distinction abuse vs dependency (Clark, 2004). Even then, a high proportion of addicts would not be engaged in treatment services and therefore would be excluded from statistics. While it is therefore impossible to provide a figure for the exact number of adolescent addicts in the UK, we can use data taken from adolescents receiving help to estimate shared characteristics of young addicts (figures 1 and 2).

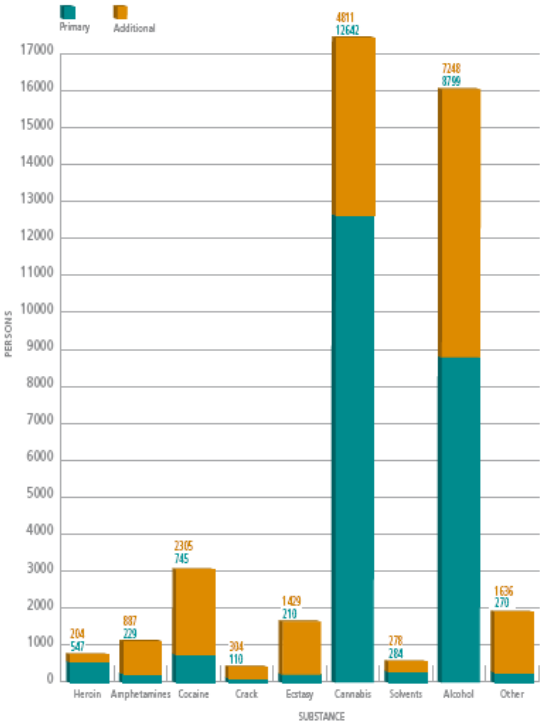


Figure 2: Number of under-18s in treatment by primary and additional substance (from NTASM, 2009)

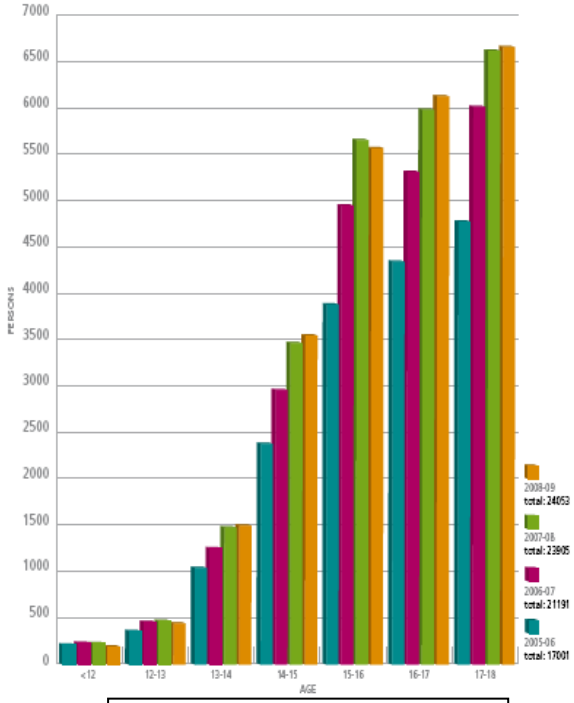


Figure 1: Numbers accessing treatment services by age, from 2005-6 to 2008/2009 (from NTASM, 2009)

Relevant Theories of Addiction

The past 40 years has seen the development of many psychosocial theories relevant to adolescent drug misuse and addiction. It is important to understand the evidence behind the most widely-used theories, in order to judge how their existence has impacted on prevention campaigns and treatment models. Some of these theories relate to substance *misuse*: however this is intrinsically linked to addiction and therefore all theories are relevant.

In the 1970s, **tolerance/withdrawal theory** explained addiction as a purely biological process: chronic drug use leads to tolerance and therefore to increased drug use. Interestingly, the primary drug taken by most adolescents using addiction services is cannabis, which is not physiologically addictive and therefore cannot follow tolerance/withdrawal theory. A 2002 meta-analysis showed that 83.8% of adolescents receiving treatment for alcohol abuse or dependence did not report withdrawal symptoms. However, a majority of adolescents in the study admitted to 'drinking more than intended' or to 'continued use despite social or interpersonal problems caused or exacerbated by use', important DSM-IV criteria for alcohol dependence (Chung, 2002). A purely physiological model is therefore not sufficient to account for adolescent addiction.

In 1982, O'Donnell and Clayton reignited interest in the **gateway theory**. This proposes a hierarchy of drugs: from legal drugs like alcohol and cigarettes, to 'soft' illegal drugs such as cannabis, to harder (and usually more addictive) drugs, like heroin. The original 'stepping-stone theory' was completely linear, and stated that all young marijuana users would become heroin users. It was later shown that the interpretation of the data on which this theory was based was grossly inaccurate (Kandel, 2002). However, studies have

shown that the introduction of a single drug does lead to expanded drug use (Preyde and Adams, 2008).

	Crowley (*N* = 493)	Brown (*N* = 166)	Winters (*N* = 733)	PAARC (*N* = 418)
Measure	CIDI-SAM	CDDR	ADI	Modified SCID
Male (%)	83	60	63	64
White (%)	42	81	77	80
Age range (yr)	13–19	12–18	12–19	13–19
Abuse	% (Rank)	% (Rank)	% (Rank)	% (Rank)
A1 Role Obligations	45.2 (1.5)	50.0 (2)	11.9 (4)	60.0 (2)
A2 Hazardous Use	36.9 (3)	58.4 (1)	24.1 (3)	35.9 (3.5)
A3 Legal Problems	24.7 (4)	9.6 (4)	33.3 (1.5)	32.1 (3.5)
A4 Interpers Probs	50.5 (1.5)	39.8 (3)	36.0 (1.5)	71.3 (1)
Dependence				
D1 Tolerance	33.7 (2)	45.8 (3.5)	27.0 (5)	60.8 (1)
D2 Withdrawal	12.6 (5.5)	45.2 (3.5)	16.0 (6.5)	9.1 (7)
D3 Larger/Longer	32.9 (2)	56.0 (3.5)	49.4 (1)	55.7 (2)
D4 Quit/Cut Down	15.0 (5.5)	48.2 (3.5)	43.4 (3)	29.9 (5.5)
D5 Lot of Time	22.3 (5.5)	48.8 (3.5)	41.3 (3)	46.9 (3)
D6 Reduce Activ	18.9 (5.5)	56.0 (3.5)	40.2 (3)	38.3 (4)
D7 Psych/Phys	30.6 (2)	22.3 (7)	17.6 (6.5)	27.0 (5.5)

Table 2: symptoms of alcohol use as described by adolescents (from Chung, 2002)

Peer-cluster theory (Oetting and Beauvais, 1986) states that the single most important factor influencing an adolescent's substance misuse is peer influence. It purports that peers 'shape attitudes about drugs, provide drugs, provide the social contexts for drug use, and share ideas and beliefs that become the rationales for drug use'. It is different from the one-sided concept of 'peer pressure' as each member of a peer-cluster (a close, highly-influential group) is actively involved in moving the group towards the drug-taking behaviour which they believe is 'right'. There is some evidence to support this theory: studies have shown that the correlation between adolescent drug use and drug use in close associates accounts for a high proportion of variance in drug use (Oetting and Beauvais, 1987). However, there is insufficient evidence to support the claim that peer influence is the only direct link to drug use. Suggested clinical applications of this theory focused on altering the influence of the peer-cluster directly: for example counselling methods involving whole peer-clusters (Oetting and Beauvais, 1986).

Finally, in 1992, Davies linked the well-known **theory of attribution** (Kelley and Michela, 1980) to adolescent substance abuse. Attribution theory examines how people construct links between behaviours and events to try and order their perceived environment. Research shows that we are more inclined to attribute behaviours to someone's personality than the environmental context (Perkins, 1999). As a society and as individuals we see drug and alcohol abuse in others as variously shocking, disgusting, entertaining or frightening – but above all, memorable. Observers tend to emphasise these incidences rather than common everyday behaviours when forming opinions of people. Adults or outsiders may refer to a teenage alcohol or drug user in pejorative terms – 'he's a druggie, an addict, a dropout', or even attribute the adolescent's drug use to a hereditary weakness: 'he's just like his waster father'. This may lead the teenager to feel that he is destined to become an addict, so he will give up trying to effect a change. Simultaneously, resentment towards adults may increase the teenager's desire to rebel. In this way, the pejorative terms may end up as self-fulfilling prophecies (Walters, 1999).

There is strong evidence behind all three of these theories – gateway, peer-cluster and attribution. Most models traditionally used when assessing addiction – the disease model,

the psychoanalytic model, the family theory model – focus strongly on a single sphere of influence. Therefore, the recently developed biopsychosocial model is now most commonly used when considering addiction. It takes into account all three proven spheres of influence (biological, psychological and social), encompasses all proven theories of addiction and encourages holistic treatment.

The Biopsychosocial Model for Understanding and Assessing Adolescent Addiction

Before we can apply the biopsychosocial model, it is vital to examine why young people are so vulnerable to addiction. Some of the theories described above mention risk factors predisposing adolescents to drug and alcohol addiction. The biopsychosocial model provides the perfect framework for categorising these risk factors, allowing us to tackle them individually.

The only biological risk factor specific to adolescents is the new appearance of mental health co-morbidities. First presentation of schizophrenia, for instance, usually occurs between 16 and 25, and has a high association with drug misuse and addiction (Kavanagh, 2002). Other mental health problems which commonly present first in adolescence include anxiety and affective disorders, for which adolescents may self-medicate with alcohol or drugs (Zeitlin, 1999). Young people with undiagnosed ADHD may self-medicate with illegal stimulants to control their symptoms (Wilens, 2004).

There are many adolescent-specific psychological risk factors for addiction. Adolescents' increased tendency to experiment is regarded as natural; the way that they develop a unique identity and a sense of autonomy (Botvin, 1983). However, it often leads them to indulge in risk-taking behaviour (Igra and Irwin, 1996). Similarly, adolescents commonly show low regard for or poor understanding of the consequences of their actions; they may feel 'invincible' (Preyde and Adams, 2008). This is at least partly due to their immaturity and lack of life-experience (most adults will have seen first-hand the devastating consequences of severe addiction). For a similar reason, teenagers are notoriously susceptible to media influence, especially regarding substance misuse (Strasburger, 2004). Conversely, adolescent cognitive development may lead to internal rationalisations for ignoring risks of substance abuse (Botvin, 1983).

Adolescence may be emotionally traumatic, as young people encounter many new specific stresses. Friendships may change, physical and emotional relationships may begin – and end, teenagers may be expected to start working and/or sit important exams, and indeed may discover that their ambitions do not match their abilities. All of these factors can lead to a fall in self-esteem and indeed to social alienation – a proven predictor for drug misuse and addiction (Hawkins *et al*, 1992). Abnormal adolescent development (due to eg. bullying, familial neglect/abuse, traumatic events) will increase both the likelihood and impact of the above stresses. Finally, alcohol use is universally viewed as an adult behaviour; adolescents may indulge in this behaviour to feel or look more 'grown-up' (Botvin, 1983).

Broadly, social risk factors for adolescent addiction can be divided into family influence, and peer/society influence. Unsurprisingly, family dynamics play a huge part in influencing adolescents' drug and alcohol abusing behaviour. Studies have shown that low family support and parental control correlate significantly with higher levels of drinking and drug taking (Foxcroft and Lowe, 1997; Brook *et al*, 2006), and that high levels of stress and

conflict are associated with problematic alcohol use (Colder and Chassin, 1999; Brook *et al*, 2006). This is thought to be due both to the lower levels of positive parent-child involvement present in such situations, and to disruptions in child development (Ary *et al*, 1999). Young people who live with both biological parents have a significantly reduced frequency of heavy drinking than those who don't (Bjarnason *et al*, 2003), and early family breakdown is a known risk factor for heavy adolescent drug and alcohol use (Fergusson *et al,* 1995). Additionally, a family history of substance abuse is a strong predictor for adolescent use, probably due to increased availability of the substances, normalisation of substance abuse and a desire to fit in (Brook et al, 2006).

While the importance of family influence is indisputable, it is also known that during adolescence there is a decline in parental influence on the adolescent which correlates with an increase in the influence of peers and society (Utech and Hoving, 1969). Peer pressure, as described previously, greatly affects adolescents' opinions on drugs, and affiliation with 'delinquent' peers greatly increases adolescents' likelihood of substance misuse (Brook *et al*, 1990).

Society and in particular the media also plays an important role in influencing adolescents to experiment with drugs and alcohol. Adolescent TV dramas invariably include scenes of binge drinking or drug-taking, and celebrity magazines and websites read by teenage girls contain photos of intoxicated stars stumbling out of clubs. In fact, the only media coverage which appears to be anti-substance misuse are the frequent news stories about binge drinking, which serves to normalise heavy drinking and make it seem rebellious and exciting. Alcopops are heavily advertised on TV – studies have found that they have accounted for an increase in alcohol consumption among 13 to 16 year olds (Roberts, 1999). Finally, it is important to note that adolescents have fewer day-to-day responsibilities than adults with no need to earn money in order to provide for their families. There are fewer consequences if they choose to neglect the responsibilities they do have.

	Biological	Psychological	Social
Risk factors specific to adolescents	• Co-morbidity with newly developing mental health problems	• Desire to experiment and take risks • Susceptibility to influences of media • Lack of concern for consequences • Specific emotional stresses • Abnormal adolescent development • Desire to appear adult	• Lack of positive parenting • skills/poor parent-child relationship • Poor parental monitoring • Family structure • Family history (parental influence) • Peer pressure • Social alienation • Lack of responsibility • Media targeting adolescents
General risk factors	• Family history (genes) • Co-morbidities/self-medication • Effect of substance • Withdrawal symptoms	• Personality • Emotional stress	• Ethnicity and cultural background • Socioeconomic status • Association with substance users

Table 3 above summarises the risk factors. The general risk factors are not adolescent-specific; however it is worth noting that adolescence may be the first time these risk factors become apparent. Also important is the obvious fact that while the biopsychosocial model provides an excellent template for assessing risk factors, they are not each unique to each category and each factor may influence several others. For instance, development of mental health co-morbidities may lead to bullying and therefore social alienation.

When assessing an individual who is misusing drugs or alcohol, all of these factors must be considered. A history of substance abuse must therefore be comprehensive including

not just the history of presenting complaint but also other medical history, family history and an extensive social and developmental history.

The Biopsychosocial Model for Prevention and Treatment of Adolescent Addiction

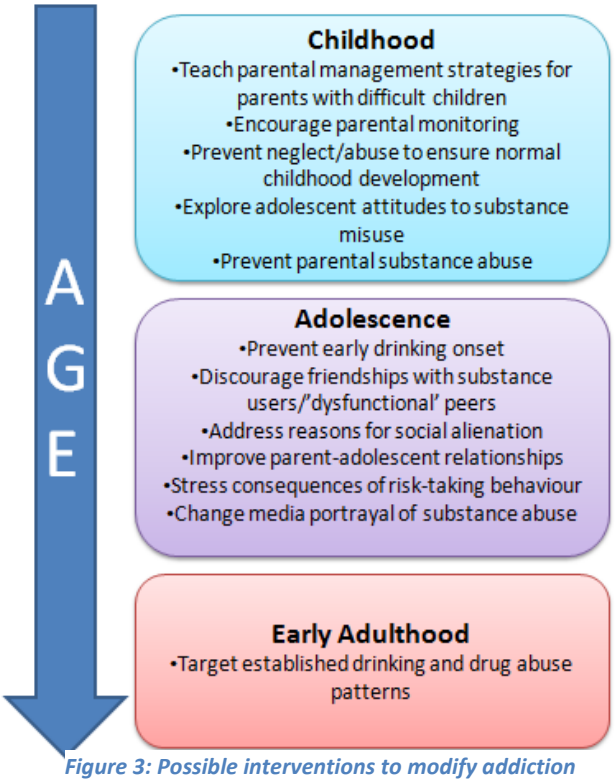


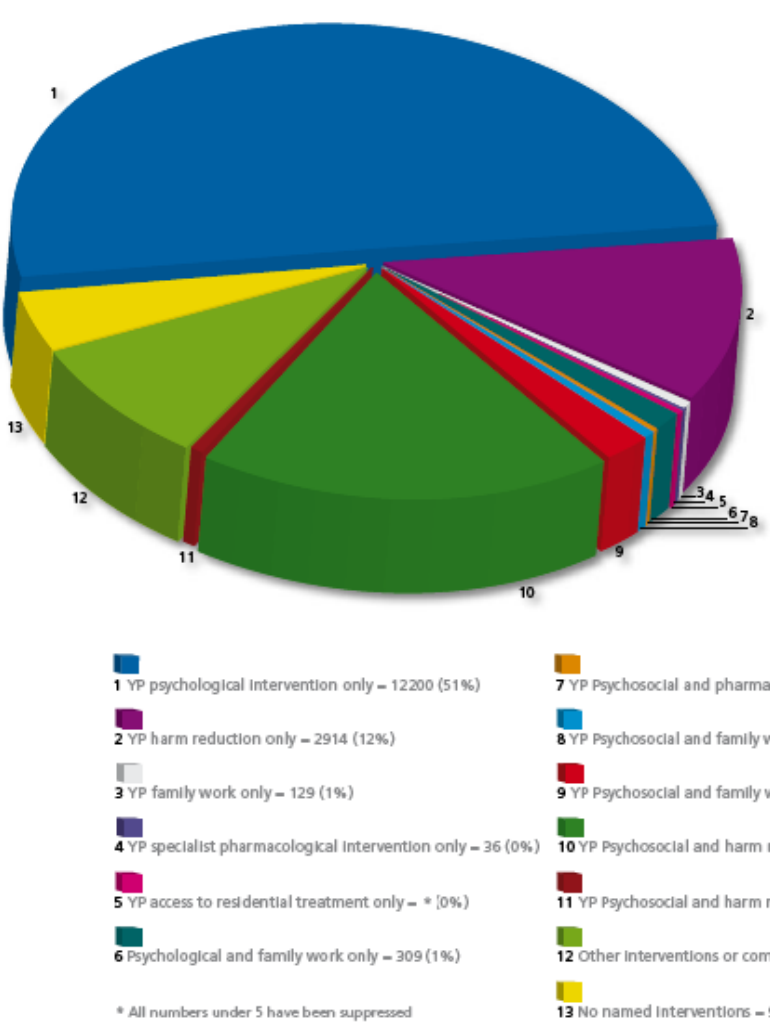
Figure 3: Possible interventions to modify addiction risk factors (created using Essau and Hutchinson, 2008)

It is clear that the aetiology of adolescent addiction differs from that of adult addiction. It is important that treatment strategies reflect this difference if they are to be effective. This is another area where the biopsychosocial model has proven to be useful and effective. Treatment for addicted adolescents is costly and time-consuming, and it is important to consider strategies to prevent addiction.

Prevention of adolescent addiction requires intervention at family, school, community and societal levels. Each of the adolescent risk factors described above should be identified and targeted – and some of this intervention must be done during early development – to give individuals the best chance of avoiding the pathways to addiction (Essau and Hutchinson, 2008) (figure 3).

Traditionally, large-scale campaigns to prevent drug and alcohol misuse have almost exclusively been education-based. These campaigns make the assumption that individuals misuse substances because they do not understand the risks. However, adolescents will naturally indulge in risk-taking behaviour and there is no solid evidence available that increased knowledge about drugs alters use or intention to use (Botvin, 1983). There is also evidence that shock tactics do not prevent young people from becoming addicted to drugs (The Independent, 2002). The most recent UK government anti-drugs campaign, Talk to FRANK, provides a mixture of education and advice, with telephone helplines and information for families and friends of users. Awareness of and reaction to the campaign has generally been good, although there is no information on the effectiveness of the program at preventing drug abuse.

Once an adolescent with a substance addiction has been identified and a comprehensive history taken, an individualised treatment plan must be drawn up. Where possible, to improve prognosis and avoid relapse the adolescent should be treated in a physically separate facility from addicted adults. Treatment must also be engaging in order to maintain young people's attention, and should endeavour to find appropriate outlets for their energy.



Young people receiving substance interventions cannot be described in the same way as adults in treatr Addiction is normally the result of consistent use of substances over t under-18s have not been taking dı enough for it to result in depender

The vast majority needed intervent as counselling, sometimes with far address the underlying causes and consequences of substance misuse young people receiving such help need support for a range of proble the breakdown of family relationsh networks and poor school attenda emotional and physical harms.

Figure 4: Interventions received by UK adolescents 2008-9 (NTASM, 2009)

Biologically, treatment of adolescents is similar to that for adults: treat physiological withdrawal and aid with detoxification pharmacologically. Young people who are using alcohol or drugs to help them cope may find safer pharmacological treatments equally effective – for example anxiolytics to control social anxiety, or sleeping tablets for insomnia. It is clearly vital to fully assess for psychiatric co-morbidities and treat these according to guidelines.

The psychological support provided by adolescent drugs units is invaluable, as it offers individualised therapy programmes tailored towards teenagers. These facilities are multidisciplinary and may offer an intensive treatment course of several sessions per week. Therapies offered include traditional counselling, CBT, family therapy, group therapy and activities and, rarely, motivational interviewing. There is evidence for the effectiveness of each of these techniques; however a combination of CBT and family therapy is most commonly used when families can be engaged, and this seems to produce the best outcomes (Ozechowski and Liddle, 2000; Kaminer *et al*, 2002). Similar therapies should be used to treat co-morbidities such as affective or anxiety disorders,

which may influence individuals' substance use. Many of the adolescent treatment centres also aim to improve self-esteem by referring to youth groups, where new skills can be learned.

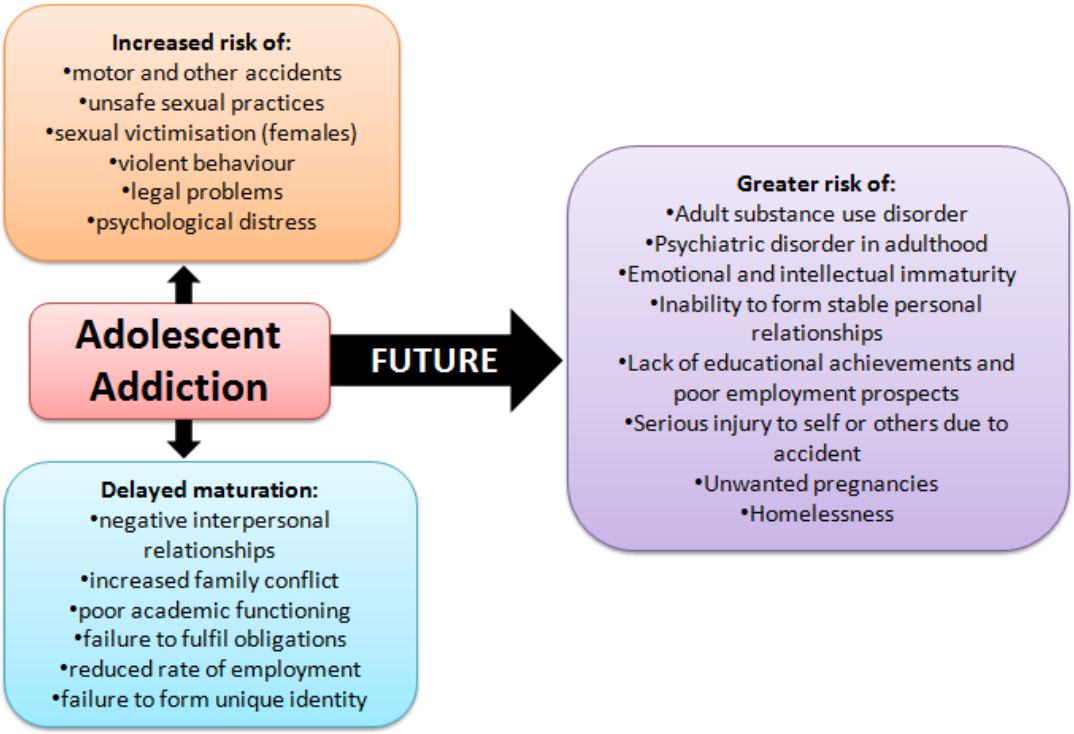
These youth groups also help adolescents to form new drug-free social circles, which is valuable both for those whose friends abuse drugs and those who feel socially alienated. They can provide schoolwork help, to enable teenagers to catch up with their peers and re-enter normal education. The adolescent treatment centres themselves often liaise with representatives from the service user's school to ensure they are meeting attendance and educational targets. Additionally where appropriate the adolescent treatment centre's multidisciplinary meetings may include representatives from the child and adolescent mental health service (CAMHS), youth offending teams and housing charities such as Second Step Bristol.

Biological	Psychological	Social
• Help with withdrawal symptoms • Provide alternatives in case of self-medication • Assess and treat co-morbidities	• Talking therapies (including CBT, motivational interviewing, multi-dimensional family therapy) • Talking therapies for mental health co-morbidities • Teach new skills	• Change environment/help forming new social circles • Help with schoolwork • Liaise with school, CAMHS, youth offending teams and housing charities (if applicable)

Table 3: Summary of treatments for adolescent addiction

Consequences of Adolescent Substance Addiction

Adolescent substance addiction, while a life-threatening and expensive problem in its own right, occurs during a formative period and therefore has several important consequences for an affected individual. Figure 6 shows some of the consequences which may occur during adolescence and later in life, and some of the reasons why the costly and intensive treatment is worthwhile in the long-term.



Importantly, studies have shown that both early age of drinking onset and alcohol abuse in adolescence is strongly correlated with increased risk of alcohol dependency in adulthood (Grant *et al*, 2001). No similar studies have examined drug dependency. Disruption in this critical period for maturation and achievement can therefore be a costly problem to the individual, the health service and society. Successful treatment of adolescent addiction can limit the damage done to a young person's prospects and prevent some of the long-term consequences displayed above.

A Case Study for Adolescent Addiction

This case study was undertaken at a Young People's Substance Misuse Treatment Service in the South West. I saw Child A, a 16 year old Caucasian male, at the adolescent addiction unit with his father. Child A was taking 13 30mg tablets of codeine phosphate per day. He has a two-year history of stealing prescription medication from family members (father's sleeping tablets and grandmother's cancer medication) and abusing cold medication for its stimulant properties. Six months ago he began taking codeine phosphate because it makes him feel 'relaxed and pure', relieves his anxiety and helps him to sleep. He has since attempted to stop on two occasions but has withdrawal symptoms of muscle aches and cramps, and severe insomnia.

Child A was diagnosed with Asperger's syndrome at age four. He was first diagnosed with generalised anxiety disorder at age 12, and has taken diazepam PRN since then. His mother has 'severe mental health problems' (not further defined) and a twenty-year history of amphetamine abuse. He is an only child and has had a tumultuous childhood. His mother often left him at home alone while she abused drugs, and until his parents' divorce in 2005 he was visited regularly by social services. The divorce was acrimonious, and in 2007 his father took out an injunction against his mother for harassment. Child A's Asperger's and anxiety limited his social interaction at school, and due to bullying he stopped attending school last year. He has no formal qualifications. Two years ago, Child A was sexually assaulted by an older man close to his home. He has described a crisis of identity and sexuality following this assault, as well as an increase in anxiety. After our meeting, Child A's father expressed concern that he may be performing sexual favours in exchange for tablets, which he refuses to confirm or deny.

Child A was appropriately dressed and appeared well presented. He did not make eye contact with anyone present, including his father. He clicked his fingers and flicked his wrist rhythmically at intervals throughout the meeting. He displayed a reactive affect, but spoke very few full sentences; the little he did speak was in a monotone and at a low volume. His mood was subjectively 'fine, anxious'. Objectively he appeared very distant and uncomfortable with the meeting. There was no evidence of any suicidal intent, thought disorder, delusions or abnormal perception. He was oriented to time, place and person and seemed cognitively normal. He does not deny his addiction and is compliant with treatment. His father describes his premorbid personality as 'nervous, angry... sort of unreachable', and 'really kind'.

Child A, while atypical in the substance abused, shows many of the typical features of addiction in an adolescent, and is best considered using the separate headings of biological, psychological and social aetiology.

Biological Aspects of Child A's Substance Addiction

Child A found the tablets to have a positive effect on his mood and outlook. He has not noticed any side-effects of intoxication. He has no daily responsibilities as he doesn't attend school or work, and he is not in a relationship, so he doesn't feel that taking the tablets causes any major life problems, although his father disagrees. When he ceases taking the drug, he experiences unpleasant symptoms – he described staying awake for three days during his last withdrawal attempt. He uses the codeine phosphate as self-medication for his severe anxiety and related insomnia, feeling that he copes better with them. Finally, he has a family history of mental health and substance abuse problems, which genetically predisposes him to both (Merikangas *et al*, 1998). Alongside this, he mentions his mother a lot and seems to feel that his drug addiction is inevitable, given her history.

Psychological Aspects of Child A's Substance Addiction

Child A's apparently withdrawn and distant premorbid personality was inextricably linked with his Asperger's diagnosis. He was clearly an anxious person, and his father described how he could 'throw tantrums which would go on for days'. This led to social isolation at school and in the community, which may have precipitated his drug abuse. His Asperger's also makes him vulnerable, leading to the possibility that he may allow himself to be sexually abused in exchange for tablets. Another way in which his Asperger's affects his drug-taking behaviour is how he enjoys the rituals of tablet taking, which also adds to the difficulty of cutting down on tablets.

Child A found his home environment very stressful as even after the divorce his mother continued to harass his father and vandalise their house. He was also badly bullied at school. These, combined with his naturally anxious personality, led to a very high baseline level of stress. Additionally, the sexual assault which took place just prior to the start of his drug abuse caused him a great deal of anxiety, probably directly precipitating the drug use.

Finally, Child A's adolescent development has been abnormal throughout due to his parents' bad divorce, his neglectful and aggressive mother, bullying and the sexual assault. All of these factors will delay his emotional and psychological development into an adult, and make him more vulnerable to addiction.

Social Aspects of Child A's Substance Addiction

Child A comes from a family with a low socio-economic status. He also reports that where he lives drug taking is 'normal' and socially acceptable. His prescription codeine tablets are free and easily available. He therefore doesn't have to resort to desperate measures such as committing crime to fund his habit; although it is unclear in what circumstances he receives the tablets. Codeine phosphate is also a licensed prescription drug, so there is no legal deterrent from possessing or taking it for him. It has also not been the focus of anti-drugs campaigns in the way that illegal opiates have, which may have dissuaded him.
Another social factor involved in his addiction is the parent-child conflict which he faces every day, due to his Asperger's. His father described how Child A is unable to differentiate emotions, and how every time his father expresses worry about his future, or his drug-seeking behaviour, he becomes aggressive and agitated as he believes his father is cross with him. Child A's father said that these misunderstandings happen on a daily basis, despite his best attempts, and may end with him taking tablets in retaliation.

Finally, social alienation in childhood is a common risk factor for adolescent drug and alcohol abuse (Hawkins *et al*, 1992). Child A has always felt unable to communicate with

his peers. He says that he has never had any friends, and he was constantly bullied at school which probably played a part in the development of his solitary drug-taking ritual.

Using the Biopsychosocial Model to Treat Child A

Child A has now been receiving treatment for three months and is an excellent example of how the biopsychosocial model can be used to treat adolescents holistically – and successfully.

Biologically, he is receiving daily prescriptions of buprenorphine (subutex), to help manage his opiate dependence. The aim of this treatment is for him to eventually stop taking codeine completely, and then gradually to reduce his buprenorphine dosage.

Psychologically, he has been receiving biweekly counselling with a clinical psychologist – one session with his father and one alone. Discussion with the psychologist revealed that topics covered include not just his drug use but the assault, his mother's neglect, his resentment towards his parents and the school bullying, as well as his fears that he is destined to become like his mother. Additionally, he is currently having a course of CBT with a specialist to help him cope with anxiety and reduce his need for medication.

Socially, the centre has been working to reduce his social alienation by providing him with details of Asperger's support groups and encouraging him to attend local youth activity groups. He has attended a few of these with his father, with varying degrees of success. They have also contacted a centre which provides free school tutoring (usually for children with learning difficulties) and are in the process of helping him to join a small group there with the aim of taking some GCSEs over the next two years.

Child A has been attending the centre for three months now, and is taking five tablets of codeine phosphate per day alongside his buprenorphine prescription, with no noticeable side-effects. He feels the CBT is very helpful, and although he still regularly gets angry at his father he now willingly attends each counselling session. His father says he feels that the time apart when he is able to resume school lessons will be beneficial and may reduce the frequency of their arguments.

	2005-06		2006-07		2007-08		2008-09	
	n	%	n	%	n	%	n	%
Complete	4105	48%	5726	50%	8073	57%	9546	65%
Referred on	572	7%	701	6%	938	7%	510	3%
Dropped out/left	2525	29%	2902	25%	2529	18%	2253	15%
Prison	200	2%	285	2%	339	2%	371	3%
Treatment declined by client	*	0%	246	2%	703	5%	620*	4%
Not known	102	1%	202	2%	98	1%	71	0%
Other	1108	13%	1448	13%	1401	10%	1250	9%
Total	8615*	100%	11510	100%	14081	100%	14620*	100%

Table 4: The excellent treatment outcomes for adolescents leaving services from 2005-6 to 2008-9 (NTASM, 2009)

Conclusion

Every year, more adolescents in the UK seek help for addiction to alcohol or drugs (23,095 in 2007-8). There is therefore a greatly increased need for young people's treatment facilities; facilities which are intensive and costly, but provide a very effective

individualised service for adolescents. The closure in February of Middlegate, the UK's last remaining adolescent only in-patient detox facility, highlights the financial struggle which the remaining day units face to continue providing adequate care to these desperate and vulnerable young people. In this essay I have used the biopsychosocial model to highlight the many areas in which adolescent addicts can be helped by intervention, and described the lifetime consequences if these services are not provided. My case study illustrates the comprehensiveness and effectiveness of the biopsychosocial model in assessing individual cases and aiding treatment services to achieve the best possible outcomes.

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Child and Adolescent Psychiatry Surveillance System (CAPSS) introduce new study

……Early Onset Psychosis

The Child and Adolescent Psychiatry Surveillance System (CAPSS) study of Paediatric Bipolar Disorder is now complete and this disorder will no longer feature on the reporting card.

The research team from Newcastle and Oxford Universities would like to thank all the Consultant Child and Adolescent Psychiatrists who reported a case and completed and returned their questionnaires. We would also like to encourage those with outstanding questionnaires to complete and forward as soon as possible.

An update of the study's findings can be downloaded from the CAPSS website at http://rcpsych.ac.uk/pdf/12%20months%20poster.pdf

CAPSS are also pleased to announce that a new study of Early Onset Psychosis has been included on our yellow card reporting system. If you are a Consultant Child & Adolescent Psychiatrists who is not receiving the monthly yellow card, and would like to contribute to reporting, please email capss@cru.rcpsych.ac.uk

Are your membership details up to date?

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

Your contributions to this Newsletter are welcome!

Please send any contributions for the next newsletter, which will be published in January 2011, to the email address below by mid December.

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The End