North West
School of Psychiatry

Child and Adolescent Module Handbook

A Psychiatry Medical Education Collaboration between Mental Health Trusts and Health Education North

MRCPSYCH COURSE

2020-2022

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Table of Contents

Semester 1

Session 1: Assessment in Child and Adolescent Psychiatry

Learning Objectives

- Undertake assessments of children and young people; to communicate effectively with children, young people and their families across the age range; to take a developmental history; to formulate and prepare a plan and identify appropriate interventions.
- Describe how the emphasis of assessments in CAMHS may be different to that in Adult Mental Health.

Curriculum Links

Child Psychiatry:

10.1 10.2 10.3 10.4 10.5 10.6

Expert Led Session

- This should include consideration of room setting e.g. with appropriate toys and other developmentally appropriate materials/approaches, the differences and similarities between adult and child psychiatry, pointers on taking a developmental history, ICD 11, DSM 5, bio-psychosocial formulation and risk assessment. Should also consider that some trainee's may have limited experience with young children but have transferrable skills in assessment.

Case Presentation

- To highlight multi-disciplinary/multiagency nature of work (should include discussion of school observation/assessment)
- To highlight bio-psychosocial formulation
- Those trainees who are not currently in a CAMHS post should contact their local CAMHS team for the suitable case for presentation.

Journal Club Presentation

Review article: Assessing anxiety disorders in children and adolescents Susan H. Spence
Journal of Child Psychology and Psychiatry, 2017, 23:3,266-282, November 2017.
https://doi.org/10.1111/camh.12251
Useful overview of different methods of assessment using anxiety as an example

Practitioner Review: Anxiety disorders in children and young people – assessment and treatment
Cathy Creswell ,Polly Waite &Jennie Hudson
Journal of Child Psychology and Psychiatry, 2020, 61:6,628-643, January 2020:
https://doi.org/10.1111/jcpp.13186
With further exploration of assessment and treatment

- The Clinical Application of the Biopsychosocial Model in Mental Health: A Research Critique: Álvarez, AS; Pagani, M; Meucci, P (2012) American Journal of Physical Medicine & Rehabilitation, 2012, 91:13, S173–S180

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Risk assessment domains and formulation
- Assessment of a young person after an episode of self-harm young people
- Local Safeguarding processes and organisational structures

MCQs

1. Patient should routinely have a neurological examination if they present with all except:

A. History of an episode of fainting

B. History of seizures

C. Developmental delay

D. Dysmorphic features

E. Abnormal gait

2. A physical risk assessment for patients with Anorexia Nervosa should include all except:

A. Assessment of BMI and weight

B. Assessment of heart rate

C. Assessment of temperature

D. Assessment of hydration status

E. Body fat % measurement

3. During an assessment of a 14 year old patient with low mood in primary care, which of the following would prompt you to refer to specialist CAMHS:

A. Mild depressive episode in those who have not responded to interventions after 2-3 months

B. Active suicidal plans

C. Referral requested by the young person

D. Moderate to severe depressive episode.

E. All of the above

4. Assessment of ADHD commonly include all except:

A. Baseline liver function tests (blood tests)

B. School observations

C. History from parents/carers

D. Questionnaire assessment

E. History from patient

5. Mental state examination of a 15 year old patient should include all the following except:

A. Assessment of appearance and behaviour

B. Family history

C. Assessment of speech

D. Assessment of insight

E. Assessment of cognition

6. The multi axial diagnostic formulation scheme of ICD 10 include:

A. Axis III: psychiatric disorder

B. Axis II: medical conditions

C. Axis IV: adaptive functioning

D. Axis I: psychiatric disorder

E. Axis VI: medical conditions

7. An assessment of a 3 year old with suspected Autistic Spectrum Disorder must include:

A. A home visit

B. A detailed mental state examination

C. Observation of the child interacting with others

D. All of the above A-C

E. None of the above A-C

8. CAMHS assessments in patients with speech delay should routinely include all except:

A. Family tree (genogram)

B. Family history of ASD

C. Developmental history

D. Details of whether the patient had the combined MMR vaccine

E. Medical history

9. The presence of a disorder can be explained in terms of all except:

A. Predisposing factors

B. Precipitating factors

C. Perpetuating factors

D. Petulant factors

E. Protective factors

10. In regards to initial CAMHS assessment of children under 5 with speech delay:

A. You should not see them without the presence of their parent/carer in the room

B. You should aim to get the child sat down in a chair for the majority of the assessment

C. You should observe them playing and play too if appropriate

D. You should avoid difficult topics

E. You should use more directed questioning

Additional Resources / Reading Materials

1. Practice Parameters for the Psychiatric Assessment of Children and Adolescents. J. Am. Acad. Child Ado/esc. Psychiatry. 1997,31:1386-1402. J. Am. Acad. Child Ado/esc. Psychiatry. 1997.36(10 Supplement):45-20S. https://www.jaacap.org/article/S0890-8567(09)62591-0/fulltext

2. And for toddlers (1997) https://www.jaacap.org/article/S0890-8567(09)62592-2/fulltext

3. Practice Parameter for the Assessment of the Family. J. Am. Acad. Child Adolesc. Psychiatry, 2007;46(7):922Y937 https://www.jaacap.org/article/S0890-8567(09)62183-3/fulltext

4. Wolpert, M., Ford, T., Trustam, E., Law, D.,Deighton, J., Flannery, H., and Fugard R. J. B. (2012) Patient-reported outcomes in child and adolescent mental health services (CAMHS): Use of idiographic and standardized measures, Journal of Mental Health, 21:2, 165-173

5. H all, C.L., Moldavsky, M., Baldwin, L. *et al.* The use of routine outcome measures in two child and adolescent mental health services: a completed audit cycle. *BMC Psychiatry* **13,** 270 (2013). https://doi.org/10.1186/1471-244X-13-270

6. Drawing helps children to talk about their presenting problems during a mental health assessment Junie Woolford et al Clinical Child Psychology and Psychiatry, vol. 20, 1: pp. 68-83. , July, 2013

Books

- Child and Adolescent Psychiatry. Robert Goodman and Stephen Scott. Third Edition (2012)
- Child and Adolescent Psychiatry: A Developmental Approach. 4th ed. Jeremy Turk, Philip Graham, Frank C Verhulst (2007)
- Clinical topics in Child and adolescent psychiatry Sarah Huline-Dickens (2014)

E-Learning

RCPsych TRon Modules

1. Including:

   Conceptualising and studying development

   The development of temperament, language and cerebral functions modules

   Adolescence and sexual development

   Family relationships

2. The neurological examination

   Not specific to children but generally useful in assessment. In this podcast Professor Adam Zeman, Professor of Cognitive and Behavioural Neurology at the University of Exeter Medical School, explains to Dr Raj Persaud how to conduct a neurological examination.

   http://www.psychiatrycpd.org/default.aspx?page=20900

Journal Articles

- The Child and Adolescent Psychiatric Assessment (CAPA).

  Angold A, Prendergast M, Cox A, Harrington R, Simonoff E, Rutter M. Psychol Med. 1995 Jul;25(4):739-53.

- Measurement Issues: Neuropsychological assessment with children and adolescents; unlocking the mysticism, methods and measures with the help of Tom Swift: James Tonks Phil J. Yates Huw W. Williams Ian Frampton Alan Slater Child and Adolescent Mental Health Volume 19 (2), November 2013

  https://acamh.onlinelibrary.wiley.com/doi/10.1111/camh.12043

Session 2: Attention Deficit Hyperactivity Disorder (ADHD)

Learning Objectives

- Describe signs, symptoms and differential diagnosis of Attention Deficit Hyperactivity Disorder, and treatment options.

Curriculum Links

ADHD:

10.1 10.2 10.3 10.6 10.7 10.8.3.1 10.8.3.2 10.8.3.3 10.8.3.4 10.8.3.5

Expert Led Session

- This should consider aspects of assessment, formulation, evidence base, NICE guidelines of assessment and intervention, differential diagnosis, co-morbidities, consequences of non-treatment and impact on substance misuse.

Case Presentation

- To highlight points in assessment, use of questionnaires, use of Quantified behavioural (Qb) test, multisource information gathering, differential diagnoses and formulation.

Journal Club Presentation

- Treatment of Children With Attention-Deficit/Hyperactivity Disorder (ADHD) and Irritability: Results From the Multimodal Treatment Study of Children With ADHD (MTA) Lorena Fernandez de la Cruz, PhD, Emily Simonoff, MD, James J. McGough, MD, Jeffrey M. Halperin, PhD, L. Eugene Arnold, MD, MEd, Argyris Stringaris, MD, PhD, MRCPsych J Am Acad Child Adolesc Psychiatry 2015;54(1):62–70.
- Long-Term Outcomes of ADHD: Academic Achievement and Performance L. Eugene Arnold1, Paul Hodgkins2,3, Jennifer Kahle4, Manisha Madhoo5, and Geoff Kewley6. Journal of Attention Disorders 1–13 © 2015 SAGE Publications
- Study of user experience of an objective test (QbTest) to aid ADHD assessment and medication management: a multi-methods approach

  Charlotte L. Hall, Althea Z. Valentine, Gemma M. Walker, Harriet M. Ball, Heather Cogger, David Daley, Madeleine J. Groom, Kapil Sayal and Chris Hollis

BMC PsychiatryBMC series – open, inclusive and trusted201717:66
https://doi.org/10.1186/s12888-017-1222-5

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Medical treatment in ADHD, types of medication, pharmacokinetics, pharmacodynamics, side effect profile.
- Formal assessment tools in ADHD assessment; pros and cons.
- NICE Guidelines for ADHD .

MCQs

1. A four year old boy is brought to clinic with his parents. They report that he is inattentive at school, will not sit and play with his siblings at home and on one occasion let go of his mother's hand whilst shopping and ran out into the road. Following assessment and diagnosis, what would your initial management step be?

A. Refer patient for individualised CBT

B. Refer family for Family Therapy

C. Refer family to parent training and education sessions

D. Commence 5mg methylphenidate daily, titrating up weekly until improvement is seen

E. None of the above

3. The parents of a 5 year old girl recently diagnosed with ADHD have cancelled their second group parent training and education session. They tell you this is because their 11 year old son has learning disabilities and is wheelchair bound. They have no extended family or close friends to help with child care arrangements on the days required. What would you advise?

A. Offer to commence medication for the patient as they will not be able to attend the parent training and education sessions

B. Offer to hold individualised parent training and education sessions on a day that would better suit them

C. Discharge the family from your case load as they have missed two consecutive appointments

D. Ask them to contact children and family services to arrange child care whilst they attend the training sessions

E. None of the above

4. You have assessed a 7 year old boy with suspected ADHD in clinic. You would like to get further information about his behaviour in school from his teachers. Which of the following regarding consent to discuss the case with school is correct?

A. You will need to document that you have obtained consent from the patient's parents or carers before you contact the school for information

B. You will need to document that you have obtained consent from the patient before you contact school for information

C. You don't need consent to request information with school

D. You don't need consent to request information from school as long as you don't discuss treatment with them

E. You will need verbal consent from the patient's parents or carers before you contact the school for information

5. Following assessment of an 8 year old boy, you diagnose severe ADHD with severe impairment of functioning in both social and academic domains. What would be your initial step in management?

A. Refer family to Family Therapy

B. Refer patient for CBT

C. Refer family to parent training and education

D. Commence the patient on medication

E. None of the above

6. You wish to complete a pre-drug treatment assessment on a 7 year old girl with diagnosed severe ADHD. Which of the following is NOT routinely required?

A. Record of height and weight plotted on centile chart

B. ECG

C. Heart rate and blood pressure plotted on a centile chart

D. Mental health and social assessment

E. Assessment of cardiovascular symptoms

7. You have been seeing a 12 year old boy with ADHD. Parent training/education sessions proved ineffective. With the parents' consent you commenced the patient on low dose methylphenidate, 5mg daily. At the following review the methylphenidate is not working and the patient's behaviour continues to be impairing his social and academic functioning. You are happy that your diagnosis remains correct. He does not describe any side effects on questioning. What would your next step in treatment be?

A. Consider commencing low dose bupropion as an adjunct to methylphenidate

B. Consider stopping methylphenidate and commencing Atomoxetine

C. Stop medication and review diagnosis again

D. Consider stopping methylphenidate and commencing low dose dexamfetamine

E. Consider increasing the dose of methylphenidate

8. NICE guidance suggests that modified release preparations of methylphenidate should be considered for all the following reasons, except:

A. Convenience

B. To increase adherence

C. To help in facilitating schools who cannot safely store medication

D. Patients with co-morbid tic disorder

E. Reducing stigma

9. ICD 10 diagnosis of hyperkinetic disorder includes all the following criteria, except:

A. Inattention, hyperactivity and/or impulsivity persistent for at least 3 months

B. Symptoms are pervasive across situations

C. Symptoms are not caused by other disorders such as autism or affective disorders

D. Symptoms cause impairment in social, academic or occupational functioning.

E. All of the above

10. Adverse effects of Methylphenidate can include all, except:

A. Raised blood pressure

B. Anorexia

C. Insomnia

D. Growth acceleration

E. Exaggeration of tic disorders

Additional Resources / Reading Materials

Books

- Rutter's Child and Adolescent Psychiatry, Fifth Edition.

  Sir Michael Rutter , Dorothy Bishop, Daniel Pine, Steven Scott , Jim S. Stevenson, Eric A. Taylor, Anita Thapar

- Child and Adolescent Psychiatry. Robert Goodman and Stephen Scott. Third Edition, Wiley-Blackwell
- Attention Deficit Hyperactivity Disorder" by Professor Russell Barkley.

E-Learning

- Attention deficit hyperactivity disorder in children and adolescents. In this podcast Professor Heidi Feldman, from the Stanford University School of Medicine, talks with Dr Raj Persaud on attention deficit–hyperactivity disorder (ADHD) in children and adolescents; referring to her recent clinical review of the disorder published in the New England Journal of Medicine. http://www.psychiatrycpd.org/default.aspx?page=20527
- Neurobiology of ADHD, by Dr Katia Rubia
- http://www.psychiatrycpd.org/podcasts/neurobiologyofadhd.aspx

Guidelines

- Attention deficit hyperactivity disorder (ADHD) (CG72) http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

Further Reading Resources

Evidence-based guidelines for the pharmacological management of attention deficit hyperactivity disorder: Update on recommendations from the British Association for Psychopharmacology Blanca Bolea-Alamañac1, David J Nutt2, Marios Adamou3, Phillip Asherson4, Stephen Bazire5, David Coghill6, David Heal7, Ulrich Müller8, John Nash9, Paramalah Santosh10, Kapil Sayal11, Edmund SonugaBarke12 and Susan J Young2 for the Consensus Group

Journal of Psychopharmacology 1–25, 2014

Session 3: Autism Spectrum Disorder (ASD)

Learning Objectives

- Signs and Symptoms of Autism spectrum disorder including the triad of impairments
- Diagnostic criteria for diagnosis of ASD including the DSM 5 and ICD 10
- Causes of ASD and psychological theories of ASD including Theory of mind, Central coherence deficit and executive function.
- Interventions in ASD

Curriculum Links

Autism Spectrum Disorders:

10.8.8.1 10.8.8.2 10.8.8.3 10.8.8.4 10.8.8.5

Expert Led Session

- To cover Aetiological theories of ASD, NICE guidelines in ASD, Interventions in ASD

Case Presentation

- This should include detailed assessment which includes developmental history, information from multiple sites and multiaxial formulation (ICD 10 or DSM 5 criteria used), cover signs and symptoms, triad of impairment and interventions offered

Journal Club Presentation

- Huerta, M., Bishop, S. L., Duncan, A., Hus, V., & Lord, C. (2012). Application of DSM-5 criteria for autism spectrum disorder to three samples of children with DSM-IV diagnoses of pervasive developmental disorders. American Journal of Psychiatry, 169(10), 1056-1064.

  McPartland, J. C., Reichow, B., & Volkmar, F. R. (2012).

- Risi, Lord, Gotham, Corsello, Chrysler et al. (Sept. 2006) Zwaigenbaum, L., Bryson, S., Lord, C., Rogers, S., Carter, A., Carver, L., & Yirmiya, N. (2006). Combining Information from Multiple Sources in the Diagnosis of Autism Spectrum Disorders. Journal of Am Academy of Child & Adolescent Psychiatry, 45(9) 1094-1103

- Berihun Assefa Dachew (a1), Abdullah Mamun (a2), Joemer Calderon Maravilla (a3) and Rosa Alati Pre-eclampsia and the risk of autism-spectrum disorder in offspring: meta-analysis (a3) Br J Psychiatry. 2018 Mar;212(3):142-147. doi: 10.1192/bjp.2017.27. Epub 2018 Jan 24.
- Jonathan Green,a,d,* Tony Charman,e Helen McConachie,f Catherine Aldred,a,g Vicky Slonims,h Pat Howlin,i Ann Le Couteur,f Kathy Leadbitter,a Kristelle Hudry,e Sarah Byford,j Barbara Barrett,j Kathryn Temple,f Wendy Macdonald,c Andrew Pickles,b and the PACT Consortium, Parent-mediated communication-focused treatment in children with autism (PACT): a randomised controlled trial, Lancet. 2010 Jun 19; 375(9732): 2152–2160. doi: 10.1016/S0140-6736(10)60587-9

'555' Topics (1 slide on each topic with no more than 5 bullet points)

Interventions used in ASD and their evidence base to cover - One slide each for the following:

- Behavioural intervention e.g. riding the rapids,
- Speech and language interventions such as Early communication workshops, more than words, talkability groups
- Sleep disorders in ASD and interventions
- Social Stories in ASD

MCQs

1. The M:F ratio of Childhood Autism is:

A. 1:1

B. 2:1

C. 3:1

D. 4:1

2. The prevalence of Autism Spectrum Conditions in a school based study in UK was: A. 99 per 10,000

B. 70 per 10,000

C. 9 per 10,000

D. 1 per 10,000

3. The clinical features of Childhood Autism as described by Kanner include all the following except:

A. Autistic aloneness

B. Delayed or abnormal speech

C. An obsessive desire for sameness

D. Onset in the first one year of life

4. The following are true about the aetiology of Autism except:

A. Higher concordance among MZ twins.

B. Increased rate of perinatal complications.

C. Decreased brain serotonin levels

D. Condition is 50 times more frequent in the siblings of affected persons

5. Which of the following is false for Rett's syndrome:

A. Occurs only in boys

B. Onset between the ages of 7 and 24 months

C. Often develop autistic features and stereotypies

D. X linked dominant disorder

6. The following is false for Seizures in Autism:

A. Can affect quarter of autistic individuals with generalised learning disability

B. Affects 5% of autistic individuals with normal IQ

C. In autistic individuals with normal IQ the seizure onset is usually in early childhood.

D. In autistic individuals with generalised learning disability the seizure onset is usually in early childhood

7. The following is true about the epidemiology of Autism:

A. Prevalence is decreasing in recent years

B. Associated with high socio-economic status

C. More common in boys

D. No hereditary risk

E.

8. All the following are first line support for a child with childhood autism except:

A. Communication skills workshop

B. Behavioural support

C. Counselling and advice to parents

D. Anti-psychotic medication.

9. The following can be used in the diagnosis of a child with Autism except:

A. Autism diagnostic Inventory (ADI)

B. Autism Diagnostic Observation Schedule (ADOS)

C. Social Responsiveness Scale (SRS)

D. Check list for Autism in Toddlers (CHAT)

10. Which of the following drugs can be used in short term treatment of severe aggression in Autism under specialist supervision:

A. Risperidone

B. Diazepam

C. Lorazepam

D. Promethazine

Additional Resources / Reading Materials

Books

- Rutter's Child and Adolescent Psychiatry, Fifth Edition.
- Sir Michael Rutter , Dorothy Bishop, Daniel Pine, Steven Scott , Jim S. Stevenson, Eric A. Taylor, Anita Thapar
- Child and Adolescent Psychiatry. Robert Goodman and Stephen Scott. Third Edition, Wiley-Blackwell

E-Learning

- Autism, ethnicity and maternal immigration
- Autism has been the subject of intense public and professional attention in recent years. One of the biggest questions is what causes it. Like the discoveries made about schizophrenia in the late 20th century, we are learning that autism too has genetic and environmental determinants. Here Dr Daphne Keen discusses her paper (Keen et al, 2010) which attempts to answer the question of whether maternal immigration and ethnicity, together or in tandem, are implicated as being risk factors in young children who develop autism.

http://www.psychiatrycpd.org/default.aspx?page=10591

Guidelines

- Autism in children and young people (CG128)

http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281 Useful handbook

www.nas.org.uk

Session 4: Anxiety and Depression

Learning Objectives

- Describe how anxiety and depression may present and it's management in childhood and adolescence and the relevance of somatisation as a communication between children and their carers.

Curriculum Links

Anxiety disorders including OCD:

10.8.4.1 10.8.4.2 10.8.4.3 10.8.4.4 10.8.4.5

Affective Disorders:

10.8.5.1 10.8.5.2 10.8.5.3 10.8.5.4 10.8.5.5

Expert Led Session

- Variable presentations (with reference to developmental age) and differential diagnosis of anxiety and depression, treatment options, evidence base for treatment, NICE guidelines for depression.

Case Presentation

- Key diagnostic features (anxiety/depression/mixed disorder) and highlight aspects of management (including risk assessment) with reference to NICE guidance

Journal Club Presentation

- Outcomes of Childhood and Adolescent Depression Richard Harrington, Hazel Fudge, Michael Rutter, Andrew Pickles, Jonathan Hill, Arch Gen Psychiatry. 1990;47(5):465-473.
- Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents With Depression Treatment for Adolescents With Depression Study (TADS) Randomized Controlled trial; Treatment for Adolescents With Depression Study (TADS) Team - JAMA. 2004;292(7):807-820.
- Walkup, J.T., Albano, A.M., Piacentini, J., Birmaher, B., Compton, S.N., Sherrill, J.T., Ginsburg,
- G.S., Rynn, M.A., McCracken, J., Waslick, B. and Iyengar, S., 2008. Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. New England Journal of Medicine,

- 359(26), pp.2753-2766.
- Emslie GJ1, Mayes T, Porta G, Vitiello B, Clarke G, Wagner KD, Asarnow JR, Spirito A, Birmaher B, Ryan N, Kennard B, DeBar L, McCracken J, Strober M, Onorato M, Zelazny J, Keller M, Iyengar S, Brent D. Am J Psychiatry. 2010 Jul;167(7):782-91. Treatment of Resistant Depression in Adolescents (TORDIA): week 24 outcomes.

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Evidence based psychological interventions in the treatment of anxiety disorders and depression in children and adolescents.
- Medication treatment in Anxiety and Depression and cautions
- Nice Guidance Anxiety Disorders/Depression

MCQs

Anxiety

1. Treatment of social anxiety disorder in children and young people include all except which?

A. Group CBT

B. Individualised CBT

C. Psychoeducation

D. Skills training for parents

E. Mindfulness based therapy

2. What percentage of children and adolescents in the UK have clinically significant anxiety disorders?

A. 2-4%

B. 4-8%

C. 8-12%

D. 12-15%

E. 15-20%

3. The following regarding specific phobias are true, except:

A. Fear of animals peaks at 2-4 years of age

B. Fear of the dark peaks at 4-6 years of age

C. Fear of war is most common in adolescents

D. Fear of death peaks at 5-10 years of age

4. According to ICD10, separation anxiety can include all except:

A. Repeated nightmares involving separation

B. Preference to sleep away from home

C. School refusal

D. Getting up frequently at night to check on parents/carers

E. Persistent and unrealistic worry that harm will come to their parents/carers

5. The diagnosis of Generalised anxiety disorder in childhood includes all except:

A. Onset before 18 years of age

B. Multiple anxieties occurring across at least 2 situations

C. Feeling worn out and irritable

D. The anxiety must not be due to another condition or substance abuse

E. Occurring for over 12 months

Depression

1. The prevalence of depression in 11 – 15 year olds in the UK is:

A. 0.1% - 1%

B. 2% - 8%

C. 11% - 15%

D. 16% - 20%

E. 21 – 30%

2. A 12 year old girl is referred to the CAMHs team with symptoms of moderate – severe depression. What is your first-line treatment?

A. Commence citalopram

B. Commence fluoxetine

C. Offer a specific psychological therapy

D. Admit to an inpatient unit

E. Refer back to GP for management of symptoms

3. The below are all risk factors for completed suicide except:

A. Previous suicide attempt

B. Presence of substance/alcohol abuse

C. Presence of psychiatric disorder

D. Strong religious beliefs

E. Lack of social support

4. The use of medication in adolescents who self-harm:

A. SSRIs is recommended for reducing self-harming behaviour

B. Flupentixol is recommended for reducing self-harming behaviour

C. Is always indicated when it occurs in the context of mental illness

D. There is no evidence that medication reduces self-harming behaviour

E. Risperidone is indicated in the presence of self-harming behaviour

5. Select the correct statement from the below regarding self-harming behaviour amongst adolescents:

A. Is common under 10 years of age

B. In community surveys, it is described by 80% of the adolescent population

C. Is more common in girls than boys

D. The majority of adolescents who self-harm wish to kill themselves

E. Only around 75% of adolescents who self-harm seek help

6. Among adolescents who self-harm, risk factors for later suicide include all except:

A. Depression

B. Unclear reason for act of deliberate self-harm

C. Psychosis

D. Female gender

E. Male gender

7. Depression in children and adolescents can present in different ways. Please match the incorrect statement:

A. Adults – change of appetite with associated weight loss or weight gain. Children – similar to adults

B. Adults – loss of confidence, self esteem. Children – similar to adults

C. Adults – somatic syndrome may or may not be present. Children – somatic complaints are frequent in children

D. Adults – depressive mood for most of the day. Children – mood irritable or depressed

E. Adults – disproportionate self blame and feelings of excessive guilt or inadequacy. Children – excessive or inappropriate guilt not usually present.

8. Please select the correct statement regarding suicide amongst children and adolescents in the UK:

A. Suicide is common under the age of 12 and gets progressively rarer after

B. There are roughly five suicides per million children aged 5 – 14 per year

C. Since the mid 1990's suicide rates have increased by around 20% in both males and females

D. More female children than male children commit suicide

E. Most adolescent suicide are carefully planned in advance

9. You assess a 14 year old male who has self-harmed in the A&E department. All of the following suggest serious suicidal intent except:

A. Extensive premeditation

B. Other people informed beforehand of his intention

C. Suicide note left

D. Carried out in isolation

E. He informed someone of his actions soon after the event

10. An 8 year old girl is referred to you. For the past month she has been performing poorly in school, complains of being bored for most of the time, has run away from home on 3 occasions, and has been taken to the GP by her mother due to generalised abdominal pain, for which no cause can be found. She has a younger sibling who is 3 years old. Suggest the most likely diagnosis:

A. Factitious disorder

B. ADHD

C. Depression

D. Sibling rivalry disorder

E. Atypical autism

Additional Resources / Reading Materials

Books

- Rutter's Child and Adolescent Psychiatry, Fifth Edition.
- Sir Michael Rutter , Dorothy Bishop, Daniel Pine, Steven Scott , Jim S. Stevenson, Eric A. Taylor, Anita Thapar
- Child and Adolescent Psychiatry.
- Robert Goodman and Stephen Scott. Third Edition, Wiley-Blackwell

E-Learning

- Anxiety disorders in children
- Approximately one in ten children suffer from anxiety disorders, and in this podcast Professor Ronald Rapee gives a broad overview of the different kinds of anxiety disorders common in children. He also discusses how anxiety disorders in children compare with those in adults, and highlights the nature of findings from epidemiological studies. He talks about some of the steps in diagnosis, and the aetiology behind anxiety disorders, including genetic and behavioural factors. Treatment is also touched on as well as some of the pitfalls to beware of when diagnosing and treating anxiety in children.

http://www.psychiatrycpd.org/default.aspx?page=4873

Guidelines

- Depression in children and young people (CG28)
- Self-harm (CG16)
- Post-traumatic stress disorder (PTSD) (CG26)
- Obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD) (CG31)
- Social anxiety disorder: recognition, assessment and treatment01 [CG159] http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

Session 5: Attachment

Learning Objectives

- Describe the concept of attachment and its relevance for the mental health of children and young people.
- To understand the relevance of attachment theory to emotional development, affect regulation and relationships across the lifespan.
- To understand the different classifications of attachment, the conditions that promote healthy attachment or otherwise and the clinical relevance of failure to develop selective attachments.

Curriculum Links

Attachment disorders:

10.8.1.1 10.8.1.2 10.8.1.3 10.8.1.4 10.8.1.5

Expert Led Session

- Should cover assessment, diagnostic challenges and MDT approach in managing attachment disorder. Can also discuss the role of specialist LAC services.

Case Presentation

- To discuss key features in history and presentation and discuss overlap with intrinsic disorders, such as ASD/ADHD.

Journal Club Presentation

- Quasi-autistic patterns following severe early global privation. English and Romanian Adoptees (ERA) Study Team. Rutter M et al. J Child Psychol Psychiatry. 1999 May; 40(4): 537-49.
- Specificity and heterogeneity in children's responses to profound institutional privation. Rutter ML1, Kreppner JM, O'Connor TG; English and Romanian Adoptees (ERA) study team. Br J Psychiatry. 2001 Aug; 179:97-103.
- Genetic, environmental and gender influences on attachment disorder behaviours. Minnis H, Reekie J, Young D, O'Connor T, Ronald A, Gray A, Plomin R. Br J Psychiatry. 2007 Jun; 190:490-5.
- The impact of a statewide trauma-informed care initiative in child welfare on the well-being of children and youth with complex trauma. Bartlett, JD et al. Children and Youth Services Review. 2018 84(1), pp.110-117

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Evidence based interventions in attachment disorder
- Risk factors for attachment disorder
- Comorbid diagnosis in attachment disorder

MCQs

1. The biological basis of attachment behaviour is:

A. The child developing relationships with other children

B. The mother wanting to protect her child from any harm

C. The child seeking proximity to the attachment figure

D. The mother's instinct to rear children

E. All of the above

2. Attachment theory has been developed by:

A. Freud

B. Bowlby

C. Skinner

D. Piaget

E. Klein

3. Fearfulness and “frozen watchfulness” are part of which ICD 10 diagnosis:

A. Generalised anxiety disorder

B. Phobic anxiety disorder

C. PTSD

D. Reactive attachment disorder

E. Paranoid personality disorder

4. Select a feature that does NOT form part of Reactive Attachment Disorder (ICD 10) but points towards Pervasive Developmental Disorders:

A. Abnormal pattern of social responsiveness that improves if child is placed in normal rearing environment

B. Aggressive responses towards their own or other’s distress

C. Restricted, repetitive interests and behaviours

D. Strongly contradictory social responses

E. None of the above

5.Reactive Attachment Disorder of early infancy and childhood (DSM V) and Reactive Attachment Disorder (ICD 11) share common diagnostic criteria. Which of the following is NOT a diagnostic feature in ICD 11:

A. Developed before age of 5 years

B. Does not turn to primary caregiver for comfort

C. Does not display security seeking behaviour

D. Does not respond when comfort is offered

E. None of the above

6.Which of the following features is NOT part of Disinhibited Social Engagement Disorder (ICD 11):

A. Approaches adults indiscriminately

B. Exhibits overfamiliar behaviour with strangers

C. Features develop within the first 5 years of life

D. Occurs in the context of grossly inadequate childcare

E. Abnormal speech development including echolalia

7. Which of the following cognitive age ranges must a child reach to develop an attachment relationship:

A. 2-5 months

B. 7-9 months

C. 2 years

D. 5 years

E. 7 years

8. What is the procedure called that assesses a child's attachment behaviour:

A. Novel Situation Test

B. Attachment Assessment Procedure

C. Strange Situation Procedure

D. Mother - Infant Attachment Battery

E. None of the above

9. Symptoms of Reactive Attachment Disorder have to be present before which age:

A. 3 years

B. 9 months

C. 18 months

D. 8 years

E. 5 years

10. The current hypothesis is that Attachment Disorders develop as a result of:

A. Children having been brought up by a single parent

B. Children having had limited opportunities to form selected attachments

C. Children having received a vegetarian diet

D. Children having intrinsic difficulties in forming secure attachments

E. Children having a specific gene mutation

Additional Resources / Reading Materials

Books

- Attachment – Attachment and Loss. Bowlby J (first published 1969)
- A Short Introduction to Attachment and attachment disorder – Colby Pearce (second edition 2017)
- Why Love Matters – Sue Gerhardt

E-Learning

- Attachment and how it relates to psychiatry (podcast)

  Dr Helen Minnis discusses the issue of attachment in psychiatry and the importance of attunement in the caregiving relationship, taking a look at the current controversies over child care and giving guidance for psychiatrists on how to work with attachment difficulties.
  http://www.psychiatrycpd.org/default.aspx?page=3301

  Growing an Emotional brain: www.youtube.com/watch?v=fzn9OuBqKYs

  An introductory blog on Adverse Childhood Experiences (ACEs)

  https://www.connectedforlife.co.uk/blog/2017/6/17/the-adverse-childhood-experiences-ace-study

  And a summary of ACEs literature from a Scottish charity, with hyperlinks to a range of publications and resources, and an educational perspective

  https://www.iriss.org.uk/resources/esss-outlines/aces

Journal Articles

- The relationship between Adult Attachment and Mental Health Care utilization; a systematic review. Adams G, Wrath A, Meng X. Canadian Journal of Psychiatry 2018 Oct; 63(10): 651–660. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6187440/
- Making and Breaking of Affectional Bonds. Bowlby J BJPsych 1977 130: 201-10 and 421-431.

Guidelines

NICE guidance on Children's Attachment (2015) https://www.nice.org.uk/guidance/ng26

Session 6: Assessment of Mental Health Problems in Child & Adolescents with Intellectual Disability (ID)

Learning Objectives

- To understand the influence of developmental factors on the presentation and treatment of psychiatric disorders.
- To understand the principles and practice of assessment, diagnosis and treatment, including therapeutic modalities, psychoactive medication and environmental manipulations of patients presenting with intellectual disability

Curriculum Links

Intellectual Disability:

13.1 13.2.1 13.2.2 13.3

Expert Led Session

- Should cover assessment and the role of other professionals (OT, LD nurses, LD psychologist) and specialist schools. Evidence based management strategies.

Case Presentation

- To cover presentation and assessment of mental health problems of a child or young person with ID; including how these differ from the non ID population and management strategies (environmental, psychological and medical).
- Those trainees who are not currently in a CAMHS post should contact their local CAMHS team for the suitable case for presentation. Specifically you should identify which Consultants see Children with Learning Disabilities, so an appropriate case can be identified well in advance

Journal Club Presentation

- Vereenooghe L, Flynn S, Hastings RP, et al. Interventions for mental health problems in children and adults with severe intellectual disabilities: a systematic review. BMJ Open. 2018;8(6):e021911. Published 2018 Jun 19. doi:10.1136/bmjopen-2018-021911
- Einfeld SL, Ellis LA, Emerson E (2011) Comorbidity of intellectual disability and mental disorder in children and adolescents: A systematic review. Journal of Intellectual and Developmental Disability 36 (2) pp137-143.
- Chadwick et al, (2008). Factors associated with the risk of behaviour problems in adolescents with severe intellectual disabilities. Journal of Intellectual Disability research 52, (10),864-876.

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Cognitive assessment tools in ID (child)
- Child Development assessment tools in paediatrics
- Approaches to assessment in children and young people with limited communication

MCQs

1. People with intellectual disability have previously been classified as:

A. Mentally retarded

B. Learning disabled

C. Sub-normals

D. Imbeciles

E. All of the above

2. Intellectual disabilities are defined by which 3 core criteria?

A. Lower intellectual ability

B. Onset during childhood

C. Onset before the age of 8

D. Significant impairment of social or adaptive functioning

E. IQ scores are not fixed throughout life

3. Which of the following are generally accepted ranges (ICD-10, DSM-IV) for severity of ID (choose 4)?

A. Mild (IQ 50-70)

B. Mild (IQ 70-90)

C. Moderate (IQ 50-70)

D. Moderate (IQ 35-50)

E. Severe (IQ 20-35)

F. Severe (IQ 25-50)

G. Profound (IQ below 25)

H. Profound (IQ below 20)

4. Which of the following 2 statements are true?

A. Mild ID accounts for approximately 80% of children with ID.

B. Approximately 50% of children with ID have moderate severity.

C. Severe ID accounts for approximately 7% of the ID group.

D. Profound ID affects 10% of children with ID.

5. The prevalence and incidence of ID varies according to gender, age, ethnicity and socioeconomic circumstances. Which statement is false?

A. Studies generally report a female predominance in LD

B. Increased maternal age is likely to lead to an increase in incidence of LD

C. Ethnicity influences prevalence and incidence levels in ID due to the associated links with poverty, access to healthcare, and communications barriers amongst other factors

D. Lower socioeconomic position is associated with higher prevalence of mild and moderate LD, but not severe LD.

6. Psychiatric illnesses frequently exist comorbidly with ID. Which of the following statements is false?

A. Prevalence of psychiatric co-morbidity ranges from 30-70%

B. There is often over diagnosis of co-morbid psychiatric conditions

C. Practically all categories of mental illness are represented in the ID population

D. Co-morbid psychiatric problems can vary and change with age

7. Match the following co-morbid problems with the age group they are most likely to present in:

1. Eating and sleep disorders	A. Adolescents
2. Self-injury	B. Very young children
3. ADHD	C. School age children

8. Which one of the following psychiatric conditions is not generally associated with LD?

A. Attention deficit hyperactivity disorder

B. Mood disorders

C. Anxiety disorders

D. Psychotic illness

E. Obsessive compulsive disorder

F. Anorexia nervosa

G. Autistic spectrum disorder

9. Behavioural analysis involves which ABC?

A. Antecedents

B. Awareness

C. Boundaries

D. Behaviour

E. Consequences

F. Circumstances

10. Which statement about management of ID is inaccurate?

A. Medications are commonly under-prescribed when managing challenging behaviour associated with ID.

B. Behavioural techniques are useful in managing ID

C. Families provide the majority of support for most people with ID

D. Social services provide the majority of support for people with ID outside of families

Additional Resources / Reading Materials

Books

- Rutter's Child and Adolescent Psychiatry, Fifth Edition.
  Sir Michael Rutter , Dorothy Bishop, Daniel Pine, Steven Scott , Jim S. Stevenson, Eric A. Taylor, Anita Thapar
- Child and Adolescent Psychiatry.
  Robert Goodman and Stephen Scott. Third Edition, Wiley-Blackwell

Cerebra resources

http://w3.cerebra.org.uk/research/research-papers/self-injurious-behaviour-in-children-with-intellectual-disability/

Journal Articles

- Developing mental health services for Children and Adolescents with Learning Disability: A toolkit for clinicians
  http://www.rcpsych.ac.uk/pdf/devmhservcaldbk.pdf
- Mental health of children with learning disabilities. Pru Allington-Smith, Advances in Psychiatric Treatment, 2006, vol. 12, 130–140.

Nice Guidelines

Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges

https://www.nice.org.uk/guidance/ng11

Session 7: Eating Disorders

Learning Objectives

- To understand the principles and practice of assessment (including psychiatric comorbidity), diagnosis (including classification) and treatment, (therapeutic modalities, use of psychoactive medication) in patients presenting with Eating disorders in childhood and adolescence
- To understand the physical sequelae of Eating Disorders, medical management and paediatric liaison
- To understand the role of other key professional (e.g. dietician, therapists)
- To understand how services are configured for the management of Eating disorders

Curriculum Links

Eating disorders:

10.8.7.1 10.8.7.2 10.8.7.3 10.8.7.4 10.8.7.5

Expert Led Session

- To discuss assessment, including physical examination and management with reference to NICE and Junior MARSIPAN Guidance and MDT management.

Case Presentation

- To cover the key diagnostic features, with reference to ICD10/DSMV – including physical examination – calculation of BMI, %weight/height ratio and plotting on centile charts.

Journal Club Presentation

- Incidence of anorexia nervosa in young people in the UK and Ireland: a national surveillance study Petkova, Simic, Nicholls, Ford et al BMJ open, 2019, 9.

- A randomised controlled multicenter trial of treatments for adolescent anorexia nervosa including assessment of cost-effectiveness and patient acceptability – the TOuCAN trial. Gowers, Clark, Roberts et al Health Technology Assessment 2010; Vol. 14: No. 15

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Signs, symptoms and prevention of re-feeding syndrome.
- Therapeutic interventions for eating disorders in children and young people
- MARSIPAN Guidelines physical risk assessment in eating disorders

MCQs

1. When a child with anorexia nervosa refuses treatment that is deemed essential what do the National Institute of Clinical Excellence recommend?

A. The Mental Health Act should not be used where parents give their consent

B. Parental consent should be relied upon in cases of persistent refusal

C. A second opinion from an eating disorders specialist should be considered only as a last resort

D. If parents also refuse the treatment, the Mental Health Act should be applied

E. The Children's Act should be considered under circumstances where parents also refuse treatment

2. What is the approximate ratio of girls to boys with a diagnosis of any Eating Disorder in the UK? A. 5:1

B.10:1

C.15:1

D.20:1

E. 25:1

3. Which of the following is true?

A. In children, BMI is a stable measure of severity of Anorexia Nervosa

B. Children with Anorexia Nervosa can present with healthy weight

C. NICE recommend low dose fluoxetine for the treatment of BN

D. During treatment patients with Anorexia nervosa should be aiming for weight gain of more than 2 kg per week

E. Oestrogen administration should not be used to treat bone density problems in children

4. What medication do NICE recommend for Bulimia Nervosa?

A. Fluoxetine

B. Olanzapine

C. Venlafaxine

D. Methylphenidate

E. Mirtazepine

5. Which of the following is not a criterion for diagnosis of Anorexia Nervosa according to ICD10?

A. Endocrine dysfunction

B. Fear of fatness

C. Over-exercise

D. Food restriction

E. Weight more than 15% below expected weight for age and height

6. All of the following are often present in both Bulimia Nervosa and Anorexia Nervosa except:

A. Food restriction

B. Self induced vomiting

C. Low weight

D. Purging

E. Episodes of overeating

7. Which of the following is a necessary early treatment for life threatening low weight in a young person with an eating disorder?

A. Feeding high calorie meals

B. Thiamine replacement

C. NG tube feeding

D. CBT

E. Psychotropic medication

8. Which of the following are features of anorexia nervosa (1 or more)?

A. Low FSH, LH an Oestradiol

B. Shortened QT

C. Delayed gastric emptying

D. Reduced Growth Hormone

E. Low T3, normal TSH

F. Normocytic, normochromic anaemia

9. Which of the following are true about the long term complications of Anorexia Nervosa?

A. Pubertal delay is common

B. Osteopenia and osteoporosis are less frequent in children and adolescents than in adults

C. Catch up growth can occur with nutritional restoration

D. Hormone replacement is recommended for teenagers with Anorexia

E. Weight gain and the establishment of healthy eating habits usually results in restoration of menstruation

10. Which of the following are true regarding the prognosis of Eating Disorders:

A. Bulimia has a worse prognosis than anorexia nervosa

B. Vomiting in Anorexia Nervosa is a predictor if poor prognosis

C. The 30 year mortality rate in women with Eating Disorders has been found to be 20%

D. The mortality rate for Eating Disorders is greater than for psychiatric in patients

E. Some bone loss experienced in Anorexia Nervosa is irreversible

Additional Resources / Reading Materials

Books

- Clinical topics in Child and Adolescent Psychiatry, Sarah Huline-Dickens RCPsych 2014
- Seminars in Child and Adolescent Psychiatry (second edition) Edited by Simon Gowers, Royal college of Psychiatrists UK, Seminar Series
- Wiley: Handbook of Eating Disorders, 2d Edition Janet Treasure (Editor), Ulrike Schmidt (Editor), Eric van Furth (Editor) February 2003 ISBN: 978-0-471-49768-4

E-Learning

- Psychological treatments for children and adolescents with eating disorders: In this podcast, Professor Simon Gowers gives an overview of the different psychological therapies available for children and adolescents with eating disorders, discussing in some detail family therapy, interpersonal therapy and cognitive behavioural therapy
- http://www.psychiatrycpd.org/default.aspx?page=8284

Additional resources

- Cr189. MARSIPAN: management of really sick patients with anorexia nervosa (2nd edn) www.Rcpsych.ac.uk
- Eating disorders (CG9)

  http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281

Session 8: Legal Aspects of Child & Adolescent Psychiatry

Learning Objectives

Have an understanding of broad legal frameworks and more specific aspects of the Mental Health Act, Mental Capacity Act, Children Act with respect to children and how the law interacts with children including issues relating to confidentiality, consent, care and treatment and safeguarding

Curriculum Links

- This session overlaps with aspects of the following Individual Learning Objectives as outlined in the competency based Curriculum for Core Training (2013):

  ILO 1b, 3c, 4b,4c,4d,6a,17a,17b,17c,18a

Expert Led Session

- To cover: informed consent; assessment of competence; Mental Health Act; Mental Capacity Act; Children and Families Act.

Case Presentation

- To cover: parental responsibility; consent; assessment of competence; and consideration of legal frameworks in Child and Adolescent Psychiatry
- Examples:
  - 15 year old presents following overdose and refuses investigation and/or treatment
  - Use of The Mental Health Act in Anorexia Nervosa
  - “Zone of parental control” – treatment of young person under 16, with parental agreement.
  - Challenges in treatment of young person over 16, at risk of deliberate self-harm, refusing any disclosure to carers (parents)
  - Safeguarding aspects of a clinical case: actions taken in response to disclosures/raising concerns.

Journal Club Presentation

- The application of mental health legislation in younger children. Thomas, Chipchase, Rippon, McArdle, BJPsych Bulletin, 2015, 39, 302-304
- Seeking clarity in the twilight zone: Commentary on adolescent decision-making and the zone of parental control. Aaron K. Vallance Advances in Psychiatric Treatment, 2014 20:151- 152
- Decision-making about children's mental health care: ethical challenges. Moli Paul, Advances in Psychiatric Treatment, 2004, vol 10, 301-311

'555' Topics (1 slide on each topic with no more than 5 bullet points)

- Parental responsibility and Children Act relevant to Looked After Children
- Mental Capacity Act – Key Principles and relevance to care of Young people (under 18)
- Capacity Assessment and Gillick Competence – Key principles.
- Safeguarding: How to raise concerns
- Safeguarding: Organisational Structures (National/Local);(Trust Procedures/Regional Procedures)
- What are Serious Case Reviews: What are these?

MCQs

1. The Mental Health Act (1983, amended 2007) applies to which of the following age groups:

A. 16 and over

B. 18 and over

C. 16 – 65

D. 18 – 65

E. All age groups

2. A 15 year old boy, with a full understanding of the risks/benefits of treatment, consents to treatment for ADHD. This can be offered under the framework of:

A. The Mental Health Act

B. The Children' Act

C. Gillick competence

D. The Mental Capacity Act

E. The Family Reform Act

3. What is the definition of a child in UK child protection guidance?

A. Anyone under the age of 18

B. Anyone under the age of 16

C. Anyone under the age of 14

D. Anyone under the age of 18 in full-time education

E. Anyone under the age of 16 in full-time education

4. Which of these groups of people would not automatically qualify for Parental Responsibility (PR) under The Children Act (1989)?

A. Mothers

B. Fathers

C. Adoptive parents

D. People with special guardianship

E. An individual with an order from a Family Court

5. A 14 year old girl has delirium secondary to a urinary tract infection, and has refused IV antibiotics although has allowed nurses to site a cannula. She does not have capacity to make decisions regarding this treatment, with her delirium interfering with her ability to understand information. What would be the most likely legal framework used to treat her in this situation?

A. The Mental Capacity Act

B. The Mental Health Act

C. Gillick competence

D. The Family Reform Act

E. Consent from an individual with Parental Responsibility

6. Which of the following difficulties experienced by young people does NOT count as a mental disorder under the terms of the Mental Health Act?

A. Anorexia Nervosa

B. Learning Disability

C. Autism Spectrum Disorder

D. Alcohol dependence

E. Personality Disorder

7. What age group can be treated under the Mental Capacity Act:

A. Any age group

B. Any age group if the person with Parental Responsibility is unavailable

C. 14 and over

D. 16 and over

E. 18 and over

8. Which of the following is NOT relevant when considering the compulsory treatment of 16-18 year olds?

A. Deprivation of liberty

B. The zone of parental control

C. Consent of the person with parental responsibility

D. Gillick competence

E. The Mental Health Act

9. Which of the following would NOT be used when considering IV rehydration for a 14 year old with Anorexia Nervosa?

A. The Mental Health Act

B. Treatment with consent from the person with Parental Responsibility

C. Consent from a child with Gillick competence

D. The Mental Capacity Act

E. Emergency treatment under common law

10. There are circumstances in which the confidentiality young people can expect may have to be breached, to the extent of informing those with parental responsibility.

Which of the following is NOT an important factor in making this decision?

A. The young person's age and developmental level

B. The severity of any mental disorder

C. The closeness of the relationship with the parents

D. The presence of an Autism Spectrum Disorder

E. The degree of care and protection required

Additional Resources / Reading Materials

Books

- Rutter's Child and Adolescent Psychiatry, Fifth Edition.
  Sir Michael Rutter , Dorothy Bishop, Daniel Pine, Steven Scott , Jim S. Stevenson, Eric A. Taylor, Anita Thapar
- Child and Adolescent Psychiatry.
  Robert Goodman and Stephen Scott. Third Edition, Wiley-Blackwell
- Clinical topics in Child and Adolescent Psychiatry, Sarah Huline-Dickens RCPsych 2011

E-Learning

- Seclusion
  In this telephone interview, Dr Stephen Elsom talks from Australia on the topical issue of seclusion as an intervention for containing uncontrolled, disturbed behaviour of psychiatric patients. He discusses the research evidence regarding the use of seclusion and current thinking surrounding this practice. He also talks about methods that can be helpful to reduce the rate of seclusion used as an intervention.
  http://www.psychiatrycpd.org/default.aspx?page=4302

Guidelines

- Mental Health Law Online
  http://www.mentalhealthlaw.co.uk/Children_and_mental_health_law
- Antisocial behaviour and conduct disorders in children and young people (QS59)
  http://www.nice.org.uk/guidance/index.jsp?action=byTopic&o=7281
- A Positive and Proactive Workforce: Guidance on reducing restrictive practice in clinical and other settings. DOH
  http://www.skillsforcare.org.uk/Documents/Topics/Restrictive-practices/A-positive-and-proactive-workforce.pdf
- RCPsych CPD online
  http://www.psychiatrycpd.co.uk/learningmodules/ethicalandlegalchallenges-1.aspx