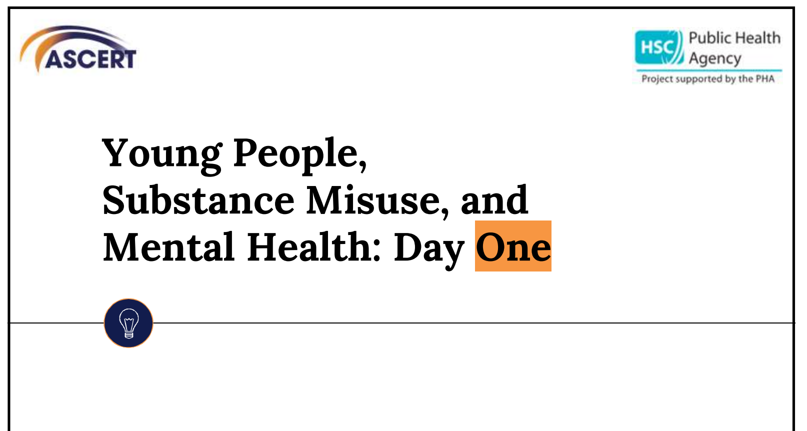
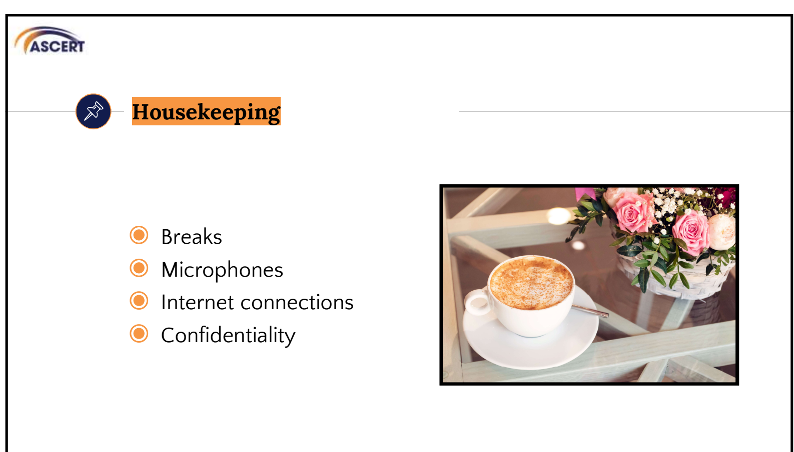
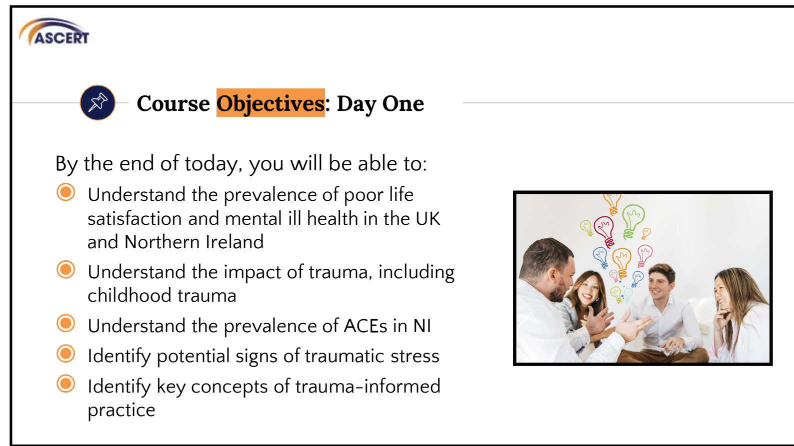
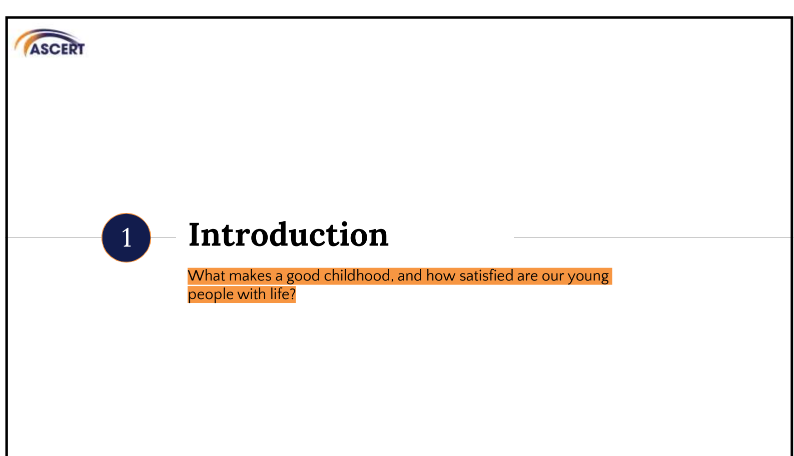
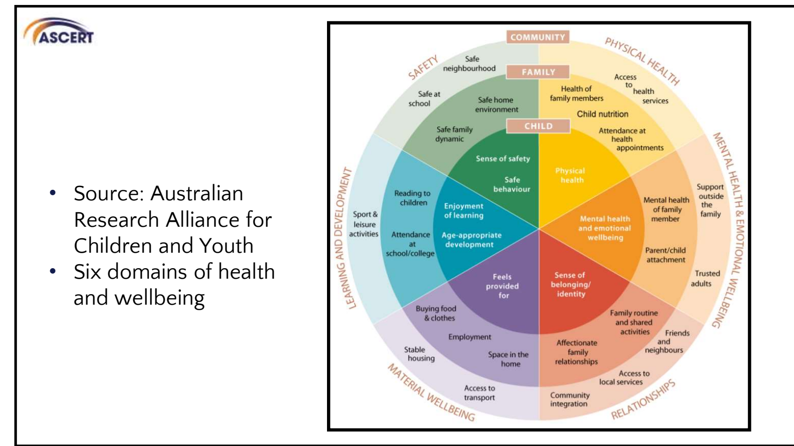

ASCERT
HSC Public Health Agency
Project supported by the PHA
Young People,
Substance Misuse, and
Mental Health: Day One

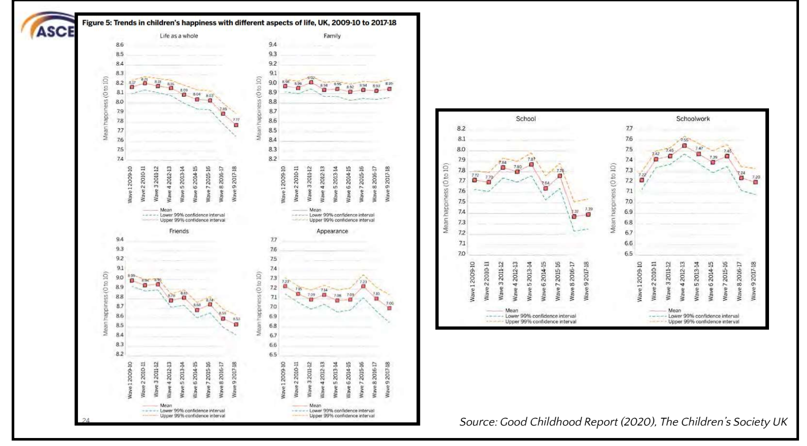

ASCERT
Housekeeping
Breaks
Microphones
Internet connections
Confidentiality

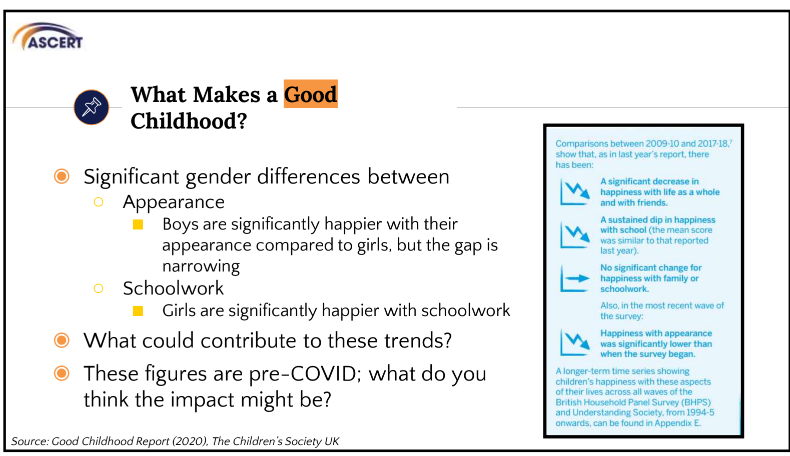

ASCERT
Course Objectives: Day One
By the end of today, you will be able to:
Understand the prevalence of poor life satisfaction and mental ill health in the UK and Northern Ireland
Understand the impact of trauma, including childhood trauma
Understand the prevalence of ACEs in NI
Identify potential signs of traumatic stress
Identify key concepts of trauma-informed practice

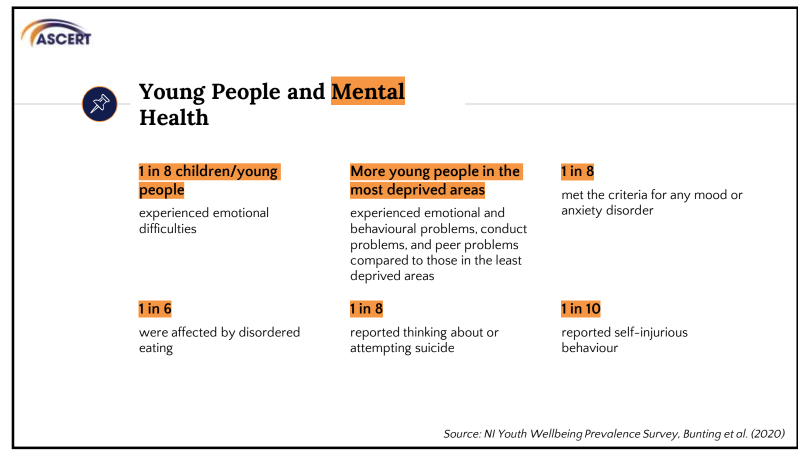

ASCERT
1
Introduction
What makes a good childhood, and how satisfied are our young people with life?

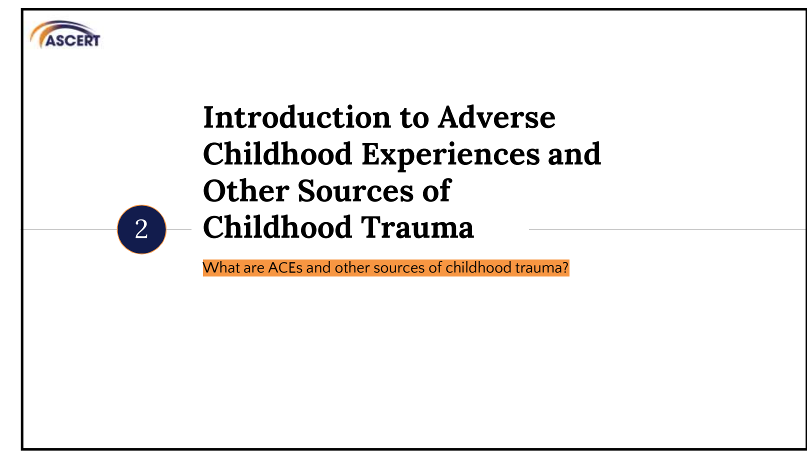
ASCERT
What makes a good childhood?
In groups, think about some qualities of a good childhood. What do you think contributes to (or is essential) for a child's happiness?

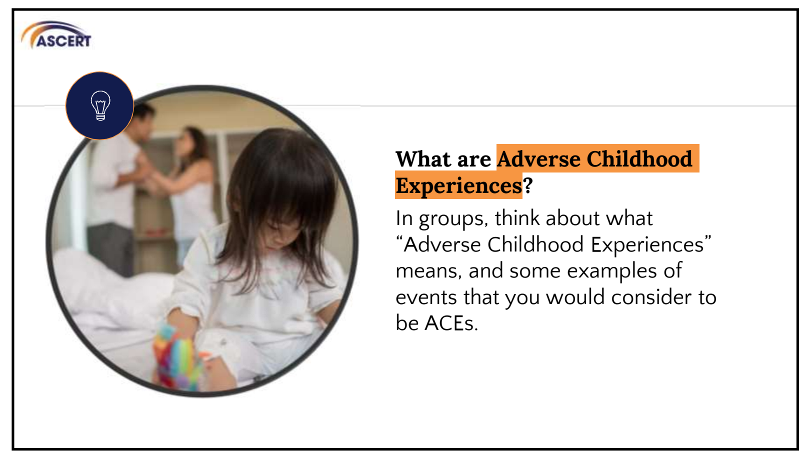

ASCERT
Source: Australian Research Alliance for Children and Youth
Six domains of health and wellbeing
COMMUNITY
FAMILY
CHILD
SAFETY
PHYSICAL HEALTH
MENTAL HEALTH & EMOTIONAL WELLBEING
RELATIONSHIPS
MATERIAL WELLBEING
LEARNING AND DEVELOPMENT
Safe neighbourhood
Safe at school
Safe home environment
Safe family dynamic
Sense of safety
Safe behaviour
Health of family members
Access to health services
Child nutrition
Attendance at health appointments
Physical health
Mental health of family member
Support outside the family
Mental health and emotional wellbeing
Parent/child attachment
Trusted adults
Sense of belonging/ identity
Family routine and shared activities
Friends and neighbours
Affectionate family relationships
Access to local services
Community integration
Feels provided for
Buying food & clothes
Employment
Stable housing
Space in the home
Access to transport
Reading to children
Enjoyment of learning
Sport & leisure activities
Attendance at school/college
Age-appropriate development

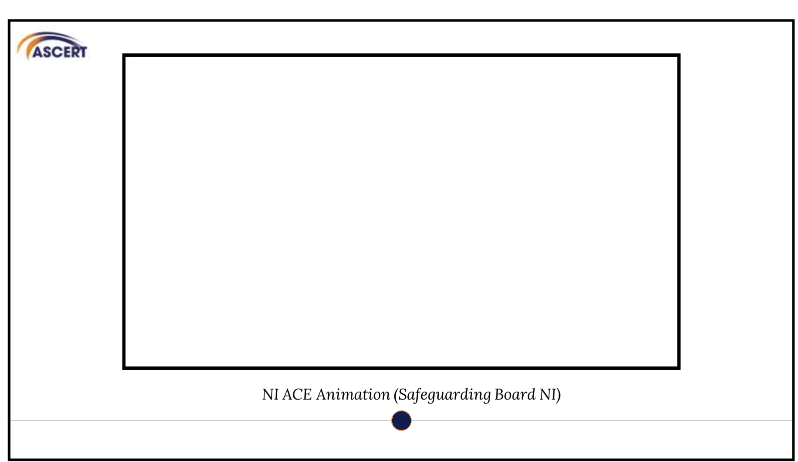

ASCERT
Figure 5: Trends in children's happiness with different aspects of life, UK, 2009-10 to 2017-18
Life as a whole
Family
Friends
Appearance
School
Schoolwork
Source: Good Childhood Report (2020), The Children's Society UK

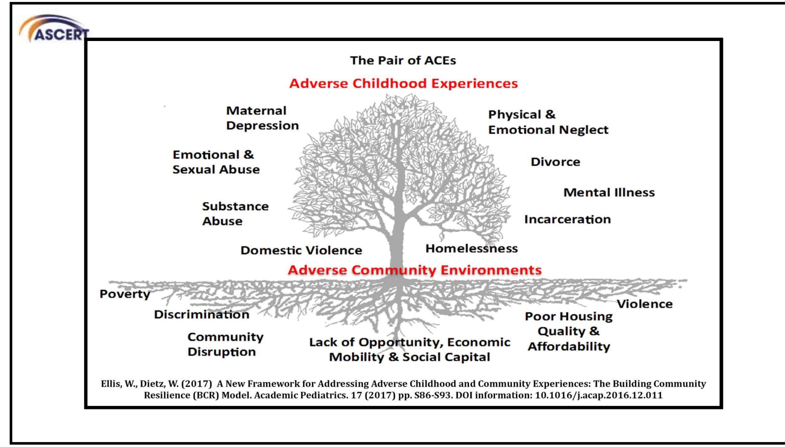

ASCERT
What Makes a Good Childhood?
Significant gender differences between
Appearance
Boys are significantly happier with their appearance compared to girls, but the gap is narrowing
Schoolwork
Girls are significantly happier with schoolwork
What could contribute to these trends?
These figures are pre-COVID; what do you think the impact might be?
Comparisons between 2009-10 and 2017-18,7 show that, as in last year's report, there has been:
A significant decrease in happiness with life as a whole and with friends.
A sustained dip in happiness with school (the mean score was similar to that reported last year).
No significant change for happiness with family or schoolwork.
Also, in the most recent wave of the survey:
Happiness with appearance was significantly lower than when the survey began.
A longer-term time series showing children's happiness with these aspects of their lives across all waves of the British Household Panel Survey (BHPS) and Understanding Society, from 1994-5 onwards, can be found in Appendix E.
Source: Good Childhood Report (2020), The Children's Society UK

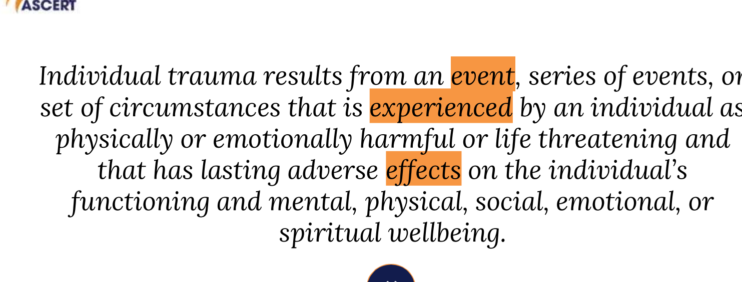

ASCERT
Young People and Mental Health
1 in 8 children/young people
experienced emotional difficulties
More young people in the most deprived areas
experienced emotional and behavioural problems, conduct problems, and peer problems compared to those in the least deprived areas
1 in 8
met the criteria for any mood or anxiety disorder
1 in 6
were affected by disordered eating
1 in 8
reported thinking about or attempting suicide
1 in 10
reported self-injurious behaviour
Source: NI Youth Wellbeing Prevalence Survey, Bunting et al. (2020)


ASCERT
2
Introduction to Adverse Childhood Experiences and Other Sources of Childhood Trauma
What are ACEs and other sources of childhood trauma?

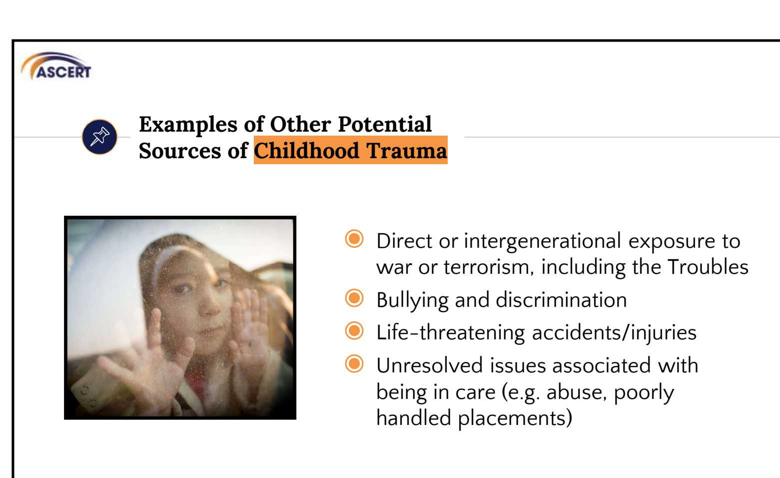

ASCERT
What are Adverse Childhood Experiences?
In groups, think about what "Adverse Childhood Experiences" means, and some examples of events that you would consider to be ACEs.

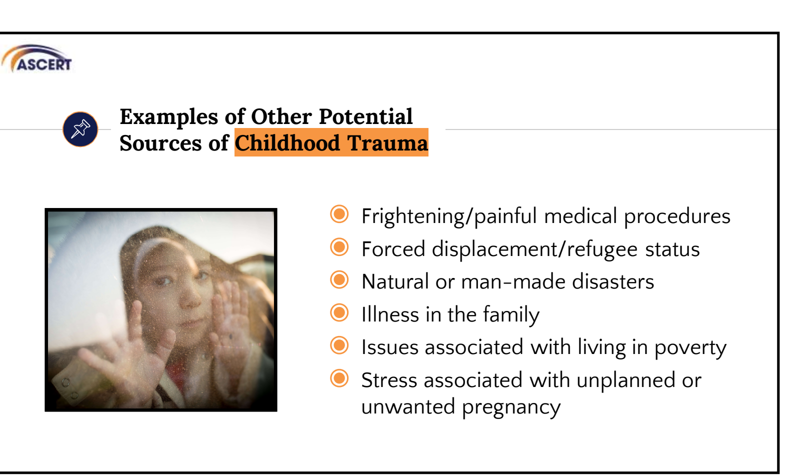

ASCERT
NI ACE Animation (Safeguarding Board NI)

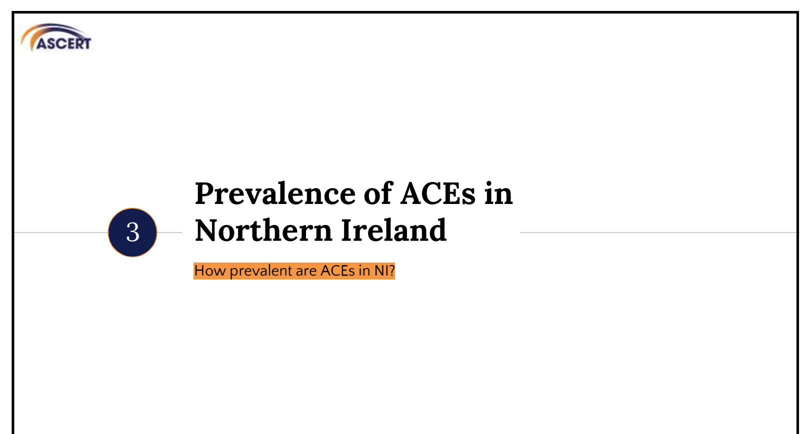


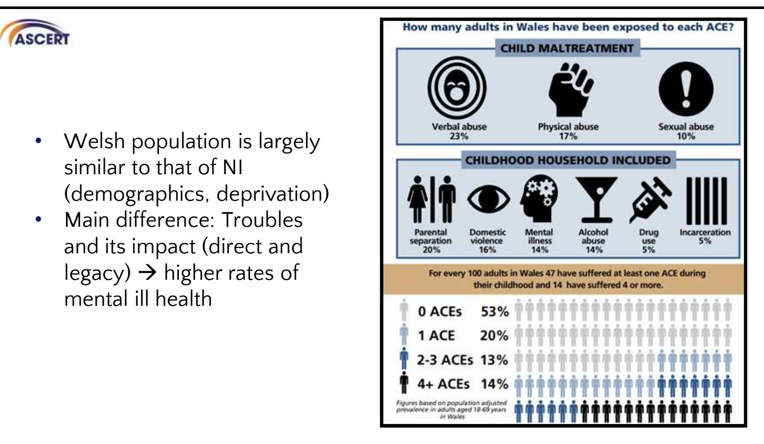


Substance Abuse and Mental Health Services Administration (SAMHSA)





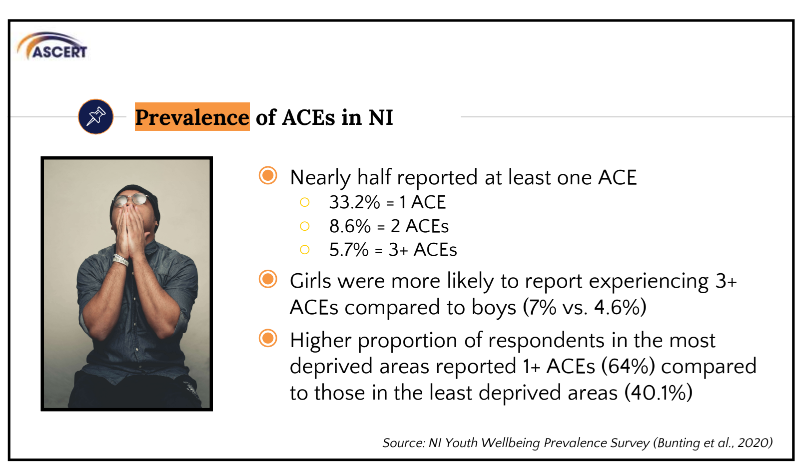


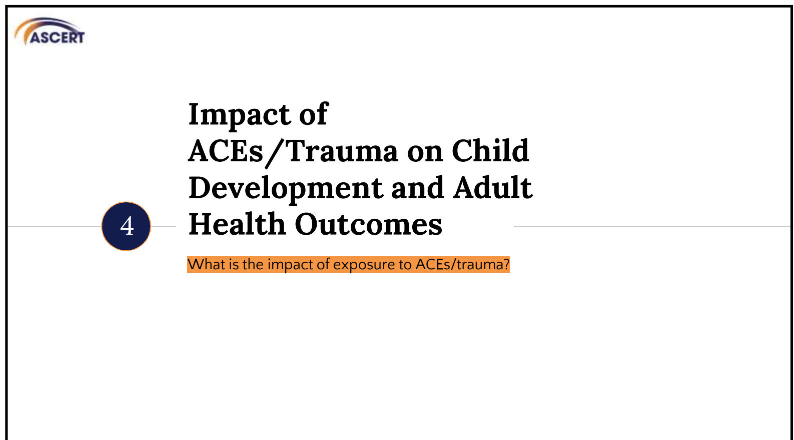


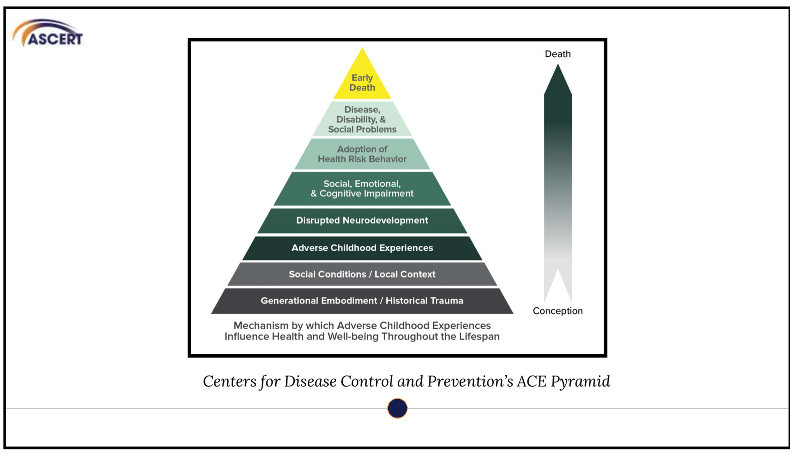
ASCERT

Source: NI Youth Wellbeing Prevalence Survey (Bunting et al., 2020)

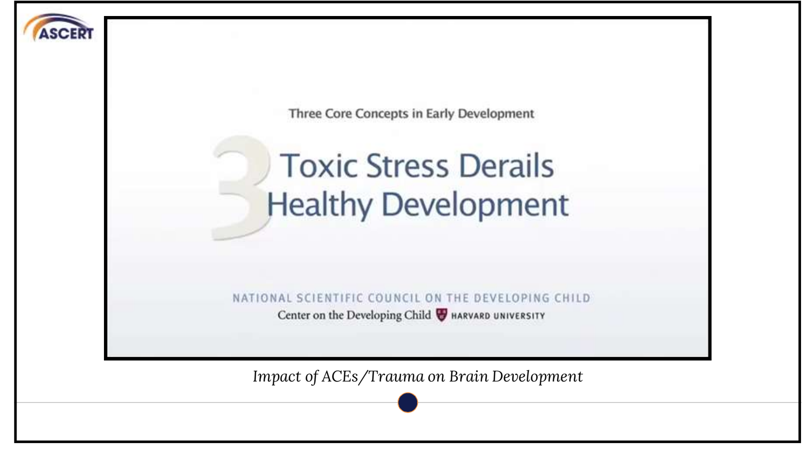
	Male	Female	Total
Emotional/Verbal Abuse	22 (3.3%)	28 (4.4%)	50 (3.9%)
Physical Abuse	27 (4.1%)	17 (2.7%)	44 (3.4%)
Sexual Abuse	13 (2%)	19 (3%)	32 (2.5%)
Emotional Neglect	**28 (4.2%)**	**46 (7.3%)**	**74 (5.7%)**
Physical Neglect	5 (0.8%)	5 (0.8%)	10 (0.8%)
Domestic Violence	23 (3.5%)	34 (5.4%)	57 (4.4%)
Parental Substance Misuse	**21 (3.2%)**	**34 (5.4%)**	**55 (4.3%)**
Parental Mental Ill Health	**53 (8%)**	**85 (13.5%)**	**138 (10.7%)**
Incarceration (Household)	9 (1.4%)	11 (1.7%)	20 (1.5%)
Parental Separation	**230 (35%)**	**230 (36.7%)**	**460 (35.8%)**







Centers for Disease Control and Prevention's ACE Pyramid



Impact of ACEs/Trauma on Brain Development

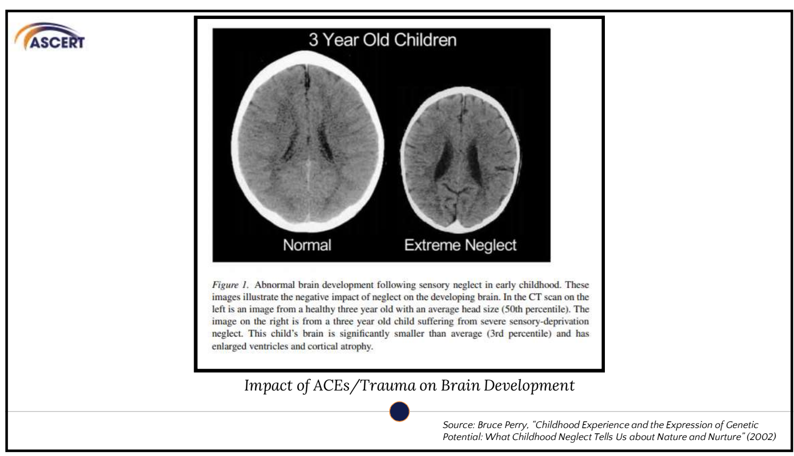
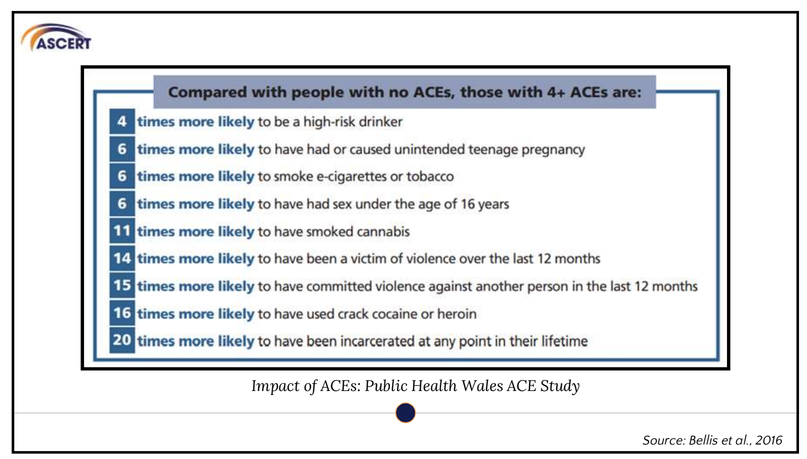
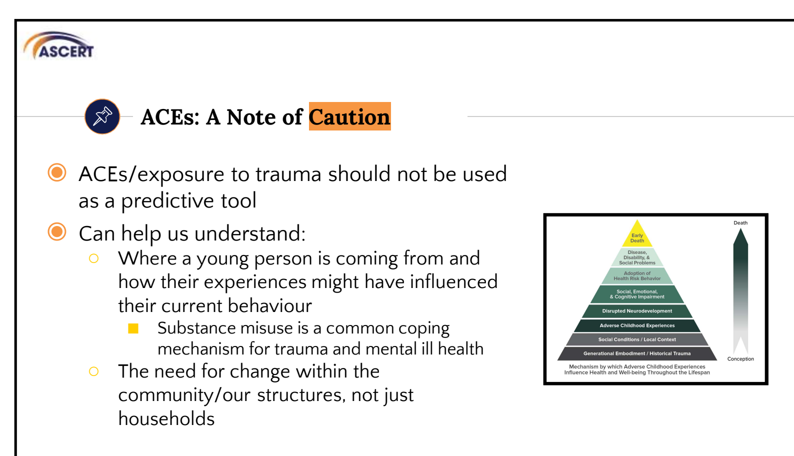


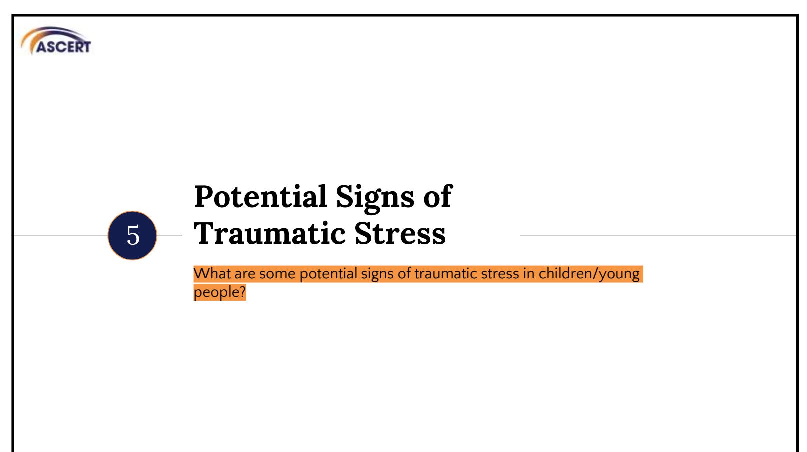
Figure 1. Abnormal brain development following sensory neglect in early childhood. These images illustrate the negative impact of neglect on the developing brain. In the CT scan on the left is an image from a healthy three year old with an average head size (50th percentile). The image on the right is from a three year old child suffering from severe sensory-deprivation neglect. This child's brain is significantly smaller than average (3rd percentile) and has enlarged ventricles and cortical atrophy.

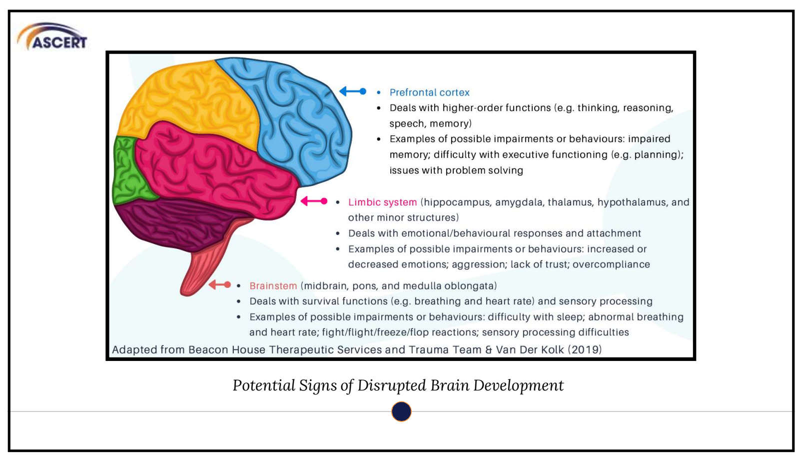
Impact of ACEs/Trauma on Brain Development

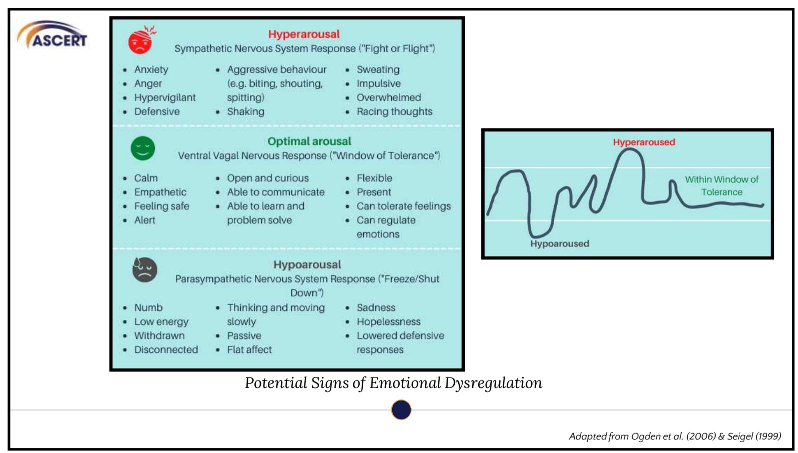
Source: Bruce Perry, "Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us about Nature and Nurture" (2002)

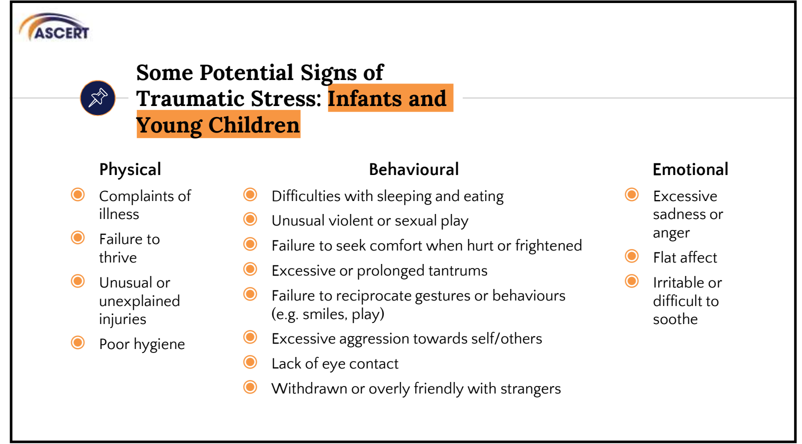

ASCERT
Compared with people with no ACEs, those with 4+ ACEs are:
4 times more likely to be a high-risk drinker
6 times more likely to have had or caused unintended teenage pregnancy
6 times more likely to smoke e-cigarettes or tobacco
6 times more likely to have had sex under the age of 16 years
11 times more likely to have smoked cannabis
14 times more likely to have been a victim of violence over the last 12 months
15 times more likely to have committed violence against another person in the last 12 months
16 times more likely to have used crack cocaine or heroin
20 times more likely to have been incarcerated at any point in their lifetime
Impact of ACEs: Public Health Wales ACE Study
Source: Bellis et al., 2016

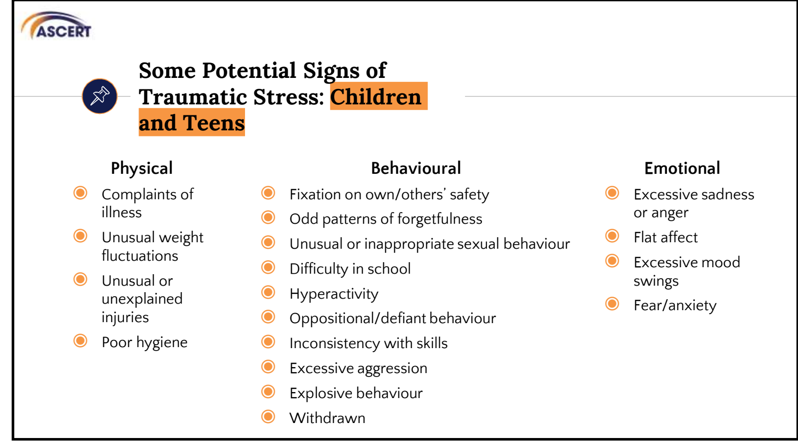

ASCERT
ACEs: A Note of Caution
ACEs/exposure to trauma should not be used as a predictive tool
Can help us understand:
Where a young person is coming from and how their experiences might have influenced their current behaviour
Substance misuse is a common coping mechanism for trauma and mental ill health
The need for change within the community/our structures, not just households

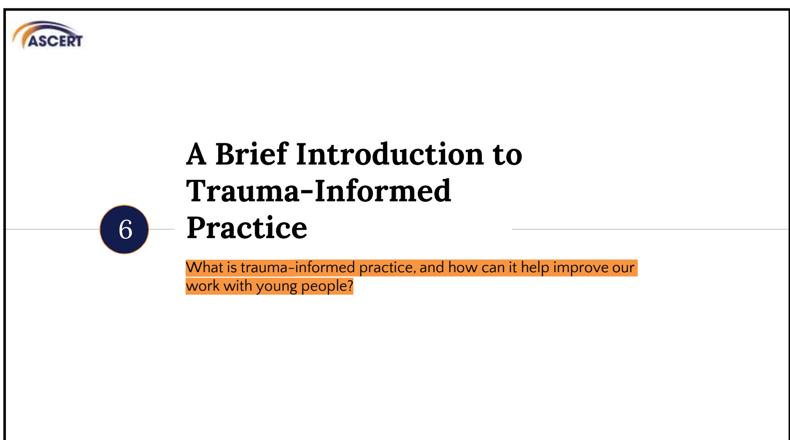

ASCERT
5
Potential Signs of Traumatic Stress
What are some potential signs of traumatic stress in children/young people?


ASCERT
Prefrontal cortex
Deals with higher-order functions (e.g. thinking, reasoning, speech, memory)
Examples of possible impairments or behaviours: impaired memory; difficulty with executive functioning (e.g. planning); issues with problem solving
Limbic system (hippocampus, amygdala, thalamus, hypothalamus, and other minor structures)
Deals with emotional/behavioural responses and attachment
Examples of possible impairments or behaviours: increased or decreased emotions; aggression; lack of trust; overcompliance
Brainstem (midbrain, pons, and medulla oblongata)
Deals with survival functions (e.g. breathing and heart rate) and sensory processing
Examples of possible impairments or behaviours: difficulty with sleep; abnormal breathing and heart rate; fight/flight/freeze/flop reactions; sensory processing difficulties
Adapted from Beacon House Therapeutic Services and Trauma Team & Van Der Kolk (2019)
Potential Signs of Disrupted Brain Development


ASCERT
Hyperarousal
Sympathetic Nervous System Response ("Fight or Flight")
• Anxiety
• Anger
• Hypervigilant
• Defensive
• Aggressive behaviour (e.g. biting, shouting, spitting)
• Shaking
• Sweating
• Impulsive
• Overwhelmed
• Racing thoughts
Optimal arousal
Ventral Vagal Nervous Response ("Window of Tolerance")
• Calm
• Empathetic
• Feeling safe
• Alert
• Open and curious
• Able to communicate
• Able to learn and problem solve
• Flexible
• Present
• Can tolerate feelings
• Can regulate emotions
Hypoarousal
Parasympathetic Nervous System Response ("Freeze/Shut Down")
• Numb
• Low energy
• Withdrawn
• Disconnected
• Thinking and moving slowly
• Passive
• Flat affect
• Sadness
• Hopelessness
• Lowered defensive responses
Hyperaroused
Within Window of Tolerance
Hypoaroused
Potential Signs of Emotional Dysregulation
Adapted from Ogden et al. (2006) & Seigel (1999)


ASCERT
Some Potential Signs of Traumatic Stress: Infants and Young Children
Physical
Complaints of illness
Failure to thrive
Unusual or unexplained injuries
Poor hygiene
Behavioural
Difficulties with sleeping and eating
Unusual violent or sexual play
Failure to seek comfort when hurt or frightened
Excessive or prolonged tantrums
Failure to reciprocate gestures or behaviours (e.g. smiles, play)
Excessive aggression towards self/others
Lack of eye contact
Withdrawn or overly friendly with strangers
Emotional
Excessive sadness or anger
Flat affect
Irritable or difficult to soothe


ASCERT
Some Potential Signs of Traumatic Stress: Children and Teens
Physical
Complaints of illness
Unusual weight fluctuations
Unusual or unexplained injuries
Poor hygiene
Behavioural
Fixation on own/others' safety
Odd patterns of forgetfulness
Unusual or inappropriate sexual behaviour
Difficulty in school
Hyperactivity
Oppositional/defiant behaviour
Inconsistency with skills
Excessive aggression
Explosive behaviour
Withdrawn
Emotional
Excessive sadness or anger
Flat affect
Excessive mood swings
Fear/anxiety


ASCERT
6
A Brief Introduction to Trauma-Informed Practice
What is trauma-informed practice, and how can it help improve our work with young people?

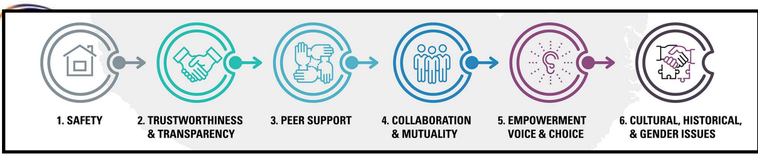
What Is Trauma-Informed Practice?

- Understanding that traumatic experiences are common
- Integrating an understanding of the physical, psychological, emotional, and spiritual impact that trauma can have in the lives of those seeking support from services
- Acknowledging that trauma can influence the relationship between service user and worker → adjusting service delivery in order to provide a sense of safety and support as needed by SU/family

Source: "Treating the Trauma Survivor: An Essential Guide to Trauma Informed Care" (Clark et al., 2015)

Why should we be trauma-informed in our work?

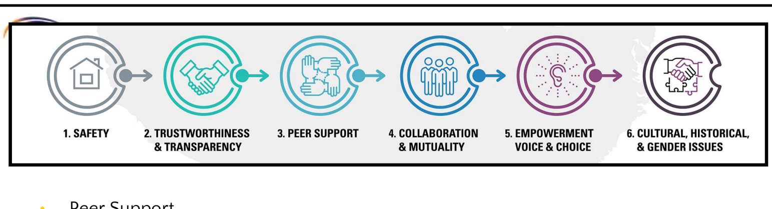
In groups, take 5 minutes to think about some reasons why we should care about being trauma-informed in our work with young people affected by substance misuse and mental ill health.



- Safety
  - Staff and service users feel safe; physical setting is safe; interpersonal interactions provide sense of safety
- Trustworthiness and Transparency
  - Organisational operations/policies are transparent → building and maintaining trust with staff and service users

CDC and SAMSHA's 6 Guiding Principles to a Trauma-Informed Approach

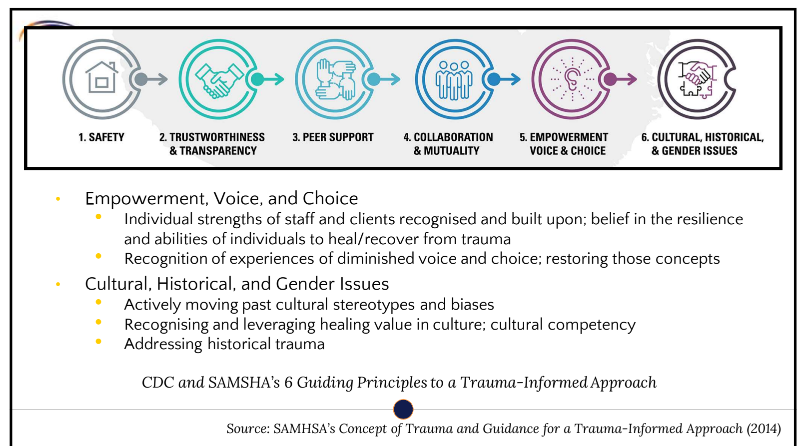
Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)

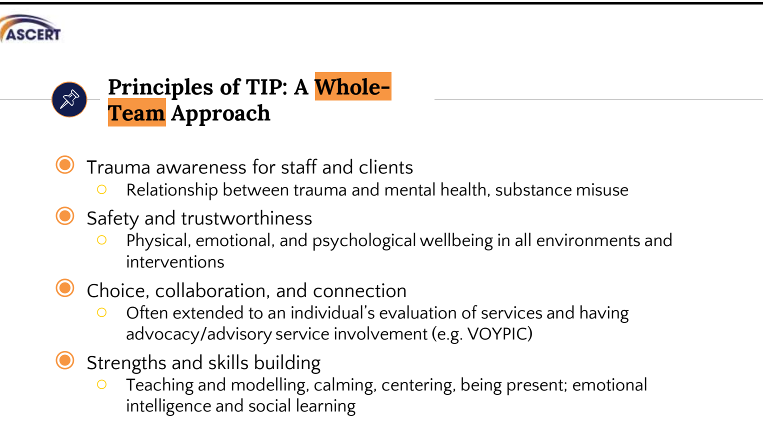


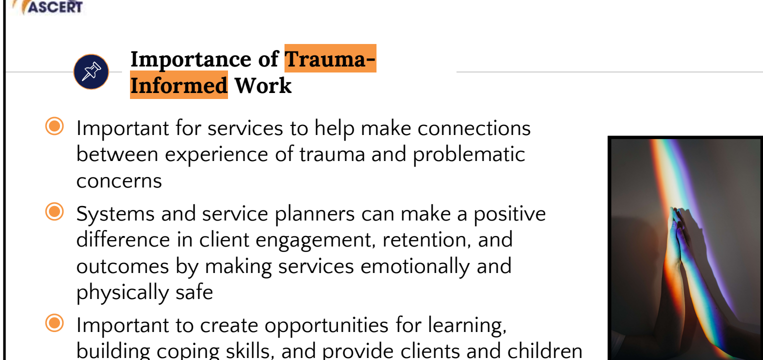
- Peer Support
  - "Peer" = people with lived experience of trauma or key caregivers in the family (for children)
  - Provide/support development of safety, hope, trust, recovery/healing, collaboration
- Collaboration and Mutuality
  - Partnering and levelling of power differences within organisation and with service users
  - "Healing happens in relationships and in the meaningful sharing of power and decision-making"

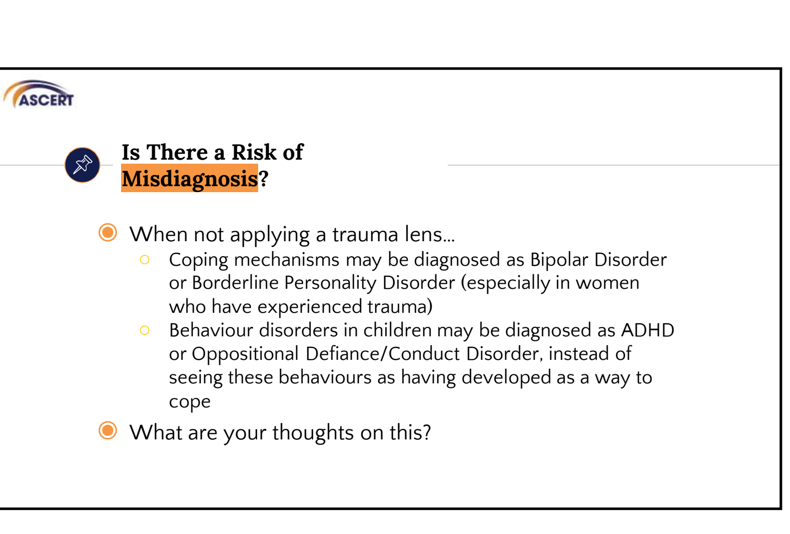
CDC and SAMSHA's 6 Guiding Principles to a Trauma-Informed Approach

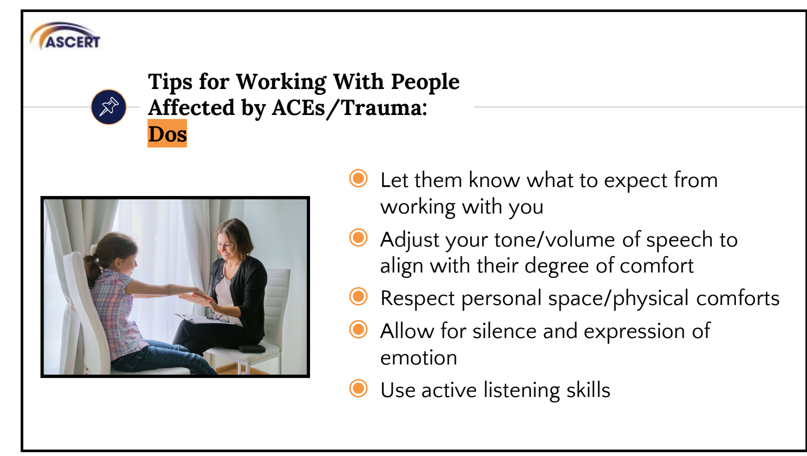
Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)

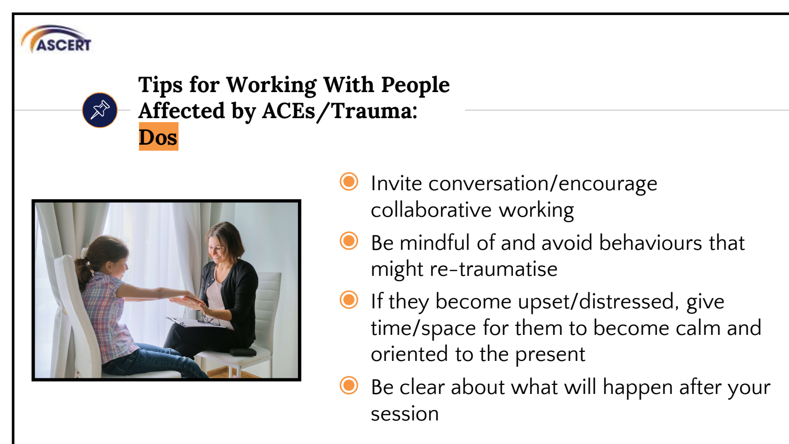

1. SAFETY
2. TRUSTWORTHINESS & TRANSPARENCY
3. PEER SUPPORT
4. COLLABORATION & MUTUALITY
5. EMPOWERMENT VOICE & CHOICE
6. CULTURAL, HISTORICAL, & GENDER ISSUES
Empowerment, Voice, and Choice
Individual strengths of staff and clients recognised and built upon; belief in the resilience and abilities of individuals to heal/recover from trauma
Recognition of experiences of diminished voice and choice; restoring those concepts
Cultural, Historical, and Gender Issues
Actively moving past cultural stereotypes and biases
Recognising and leveraging healing value in culture; cultural competency
Addressing historical trauma
CDC and SAMSHA's 6 Guiding Principles to a Trauma-Informed Approach
Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (2014)

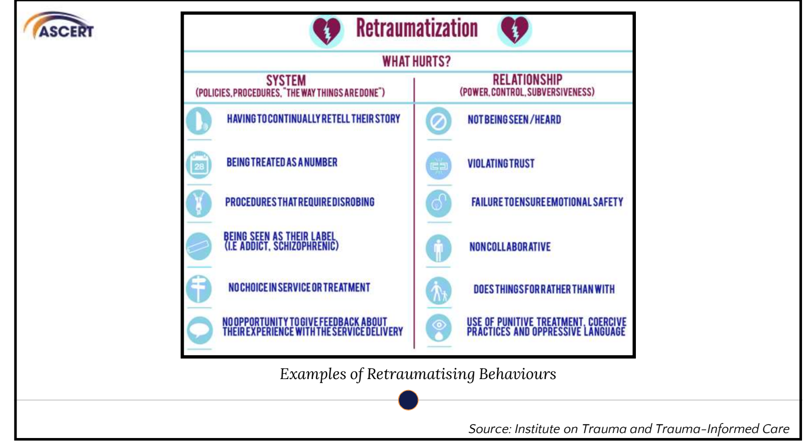

ASCERT
Principles of TIP: A Whole-Team Approach
Trauma awareness for staff and clients
Relationship between trauma and mental health, substance misuse
Safety and trustworthiness
Physical, emotional, and psychological wellbeing in all environments and interventions
Choice, collaboration, and connection
Often extended to an individual's evaluation of services and having advocacy/advisory service involvement (e.g. VOYPIC)
Strengths and skills building
Teaching and modelling, calming, centering, being present; emotional intelligence and social learning

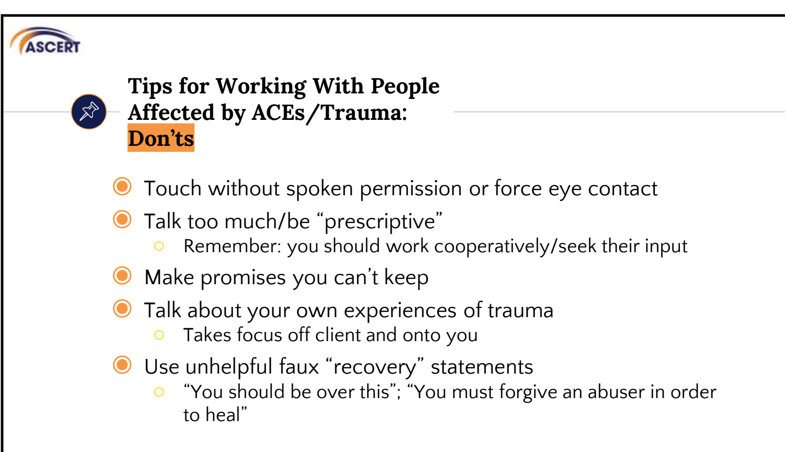

ASCERT
Importance of Trauma-Informed Work
Important for services to help make connections between experience of trauma and problematic concerns
Systems and service planners can make a positive difference in client engagement, retention, and outcomes by making services emotionally and physically safe
Important to create opportunities for learning, building coping skills, and provide clients and children with the experience of choice and control

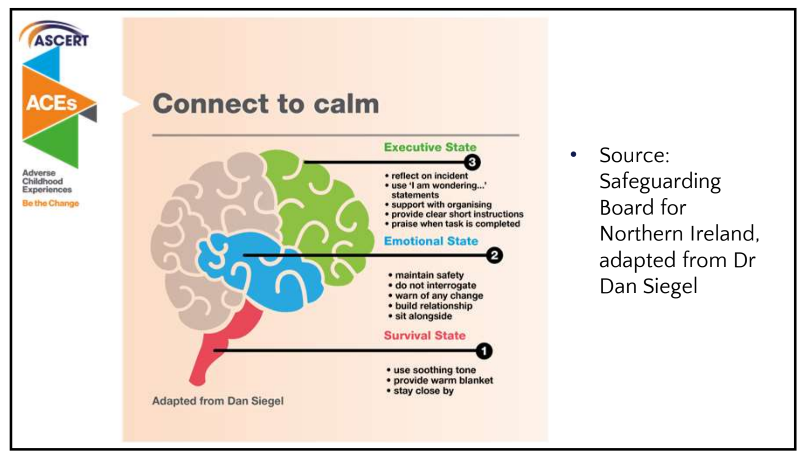

ASCERT
Is There a Risk of Misdiagnosis?
When not applying a trauma lens…
Coping mechanisms may be diagnosed as Bipolar Disorder or Borderline Personality Disorder (especially in women who have experienced trauma)
Behaviour disorders in children may be diagnosed as ADHD or Oppositional Defiance/Conduct Disorder, instead of seeing these behaviours as having developed as a way to cope
What are your thoughts on this?


ASCERT
Tips for Working With People Affected by ACEs/Trauma: Dos
Let them know what to expect from working with you
Adjust your tone/volume of speech to align with their degree of comfort
Respect personal space/physical comforts
Allow for silence and expression of emotion
Use active listening skills

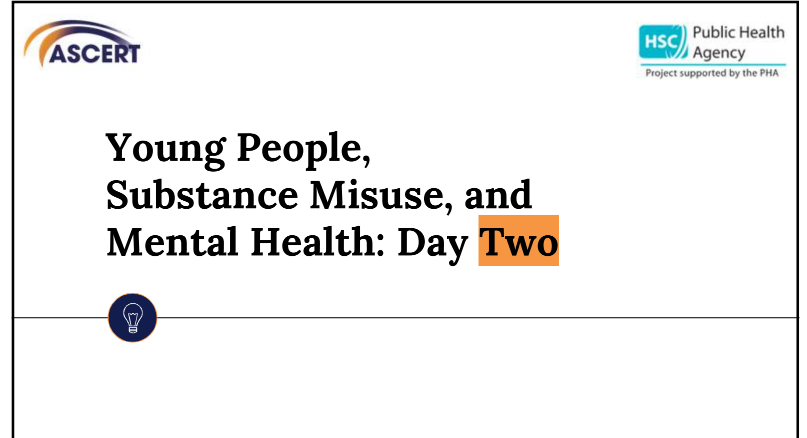

ASCERT
Tips for Working With People Affected by ACEs/Trauma: Dos
Invite conversation/encourage collaborative working
Be mindful of and avoid behaviours that might re-traumatise
If they become upset/distressed, give time/space for them to become calm and oriented to the present
Be clear about what will happen after your session

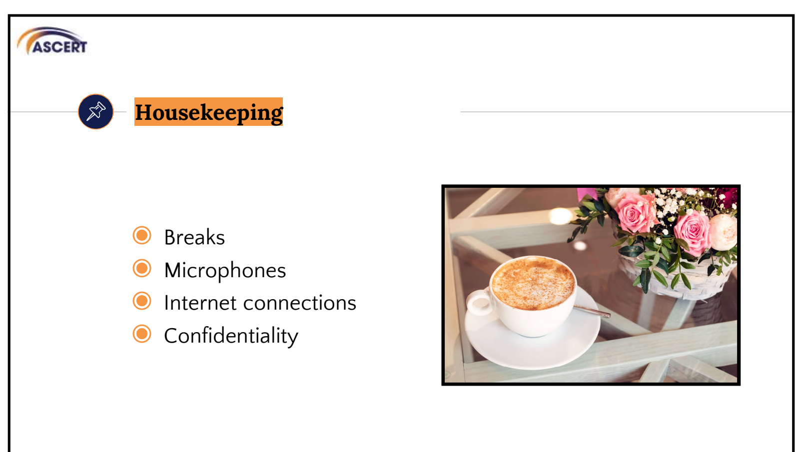

ASCERT
Retraumatization
WHAT HURTS?
SYSTEM
(POLICIES, PROCEDURES, "THE WAY THINGS ARE DONE")
RELATIONSHIP
(POWER, CONTROL, SUBVERSIVENESS)
HAVING TO CONTINUALLY RETELL THEIR STORY
NOT BEING SEEN / HEARD
BEING TREATED AS A NUMBER
VIOLATING TRUST
PROCEDURES THAT REQUIRE DISROBING
FAILURE TO ENSURE EMOTIONAL SAFETY
BEING SEEN AS THEIR LABEL (I.E. ADDICT, SCHIZOPHRENIC)
NONCOLLABORATIVE
NO CHOICE IN SERVICE OR TREATMENT
DOES THINGS FOR RATHER THAN WITH
NO OPPORTUNITY TO GIVE FEEDBACK ABOUT THEIR EXPERIENCE WITH THE SERVICE DELIVERY
USE OF PUNITIVE TREATMENT, COERCIVE PRACTICES AND OPPRESSIVE LANGUAGE
Examples of Retraumatising Behaviours
Source: Institute on Trauma and Trauma-Informed Care

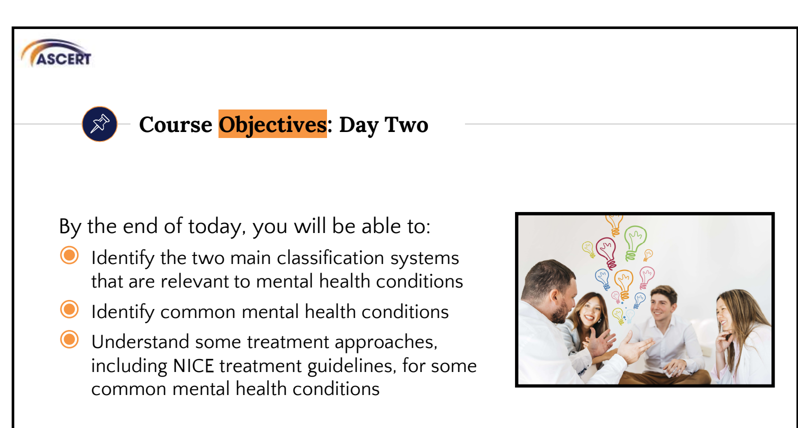

ASCERT
Tips for Working With People Affected by ACEs/Trauma: Don'ts
Touch without spoken permission or force eye contact
Talk too much/be "prescriptive"
Remember: you should work cooperatively/seek their input
Make promises you can't keep
Talk about your own experiences of trauma
Takes focus off client and onto you
Use unhelpful faux "recovery" statements
"You should be over this"; "You must forgive an abuser in order to heal"

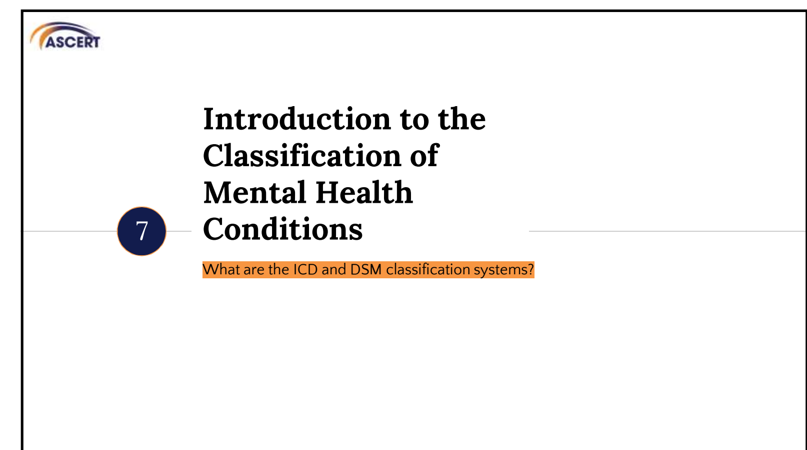

ASCERT
ACEs
Adverse Childhood Experiences
Be the Change
Connect to calm
Executive State
3
• reflect on incident
• use 'I am wondering...' statements
• support with organising
• provide clear short instructions
• praise when task is completed
Emotional State
2
• maintain safety
• do not interrogate
• warn of any change
• build relationship
• sit alongside
Survival State
1
• use soothing tone
• provide warm blanket
• stay close by
Adapted from Dan Siegel
• Source: Safeguarding Board for Northern Ireland, adapted from Dr Dan Siegel

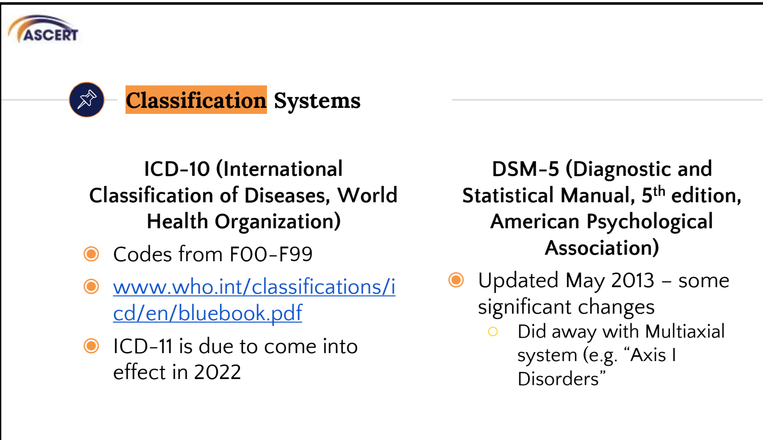
ASCERT
End of Day One

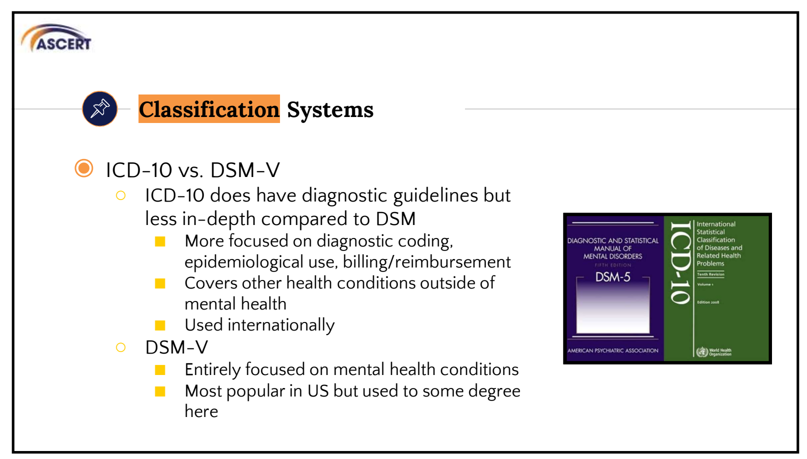

ASCERT
HSC Public Health Agency
Project supported by the PHA
Young People, Substance Misuse, and Mental Health: Day Two

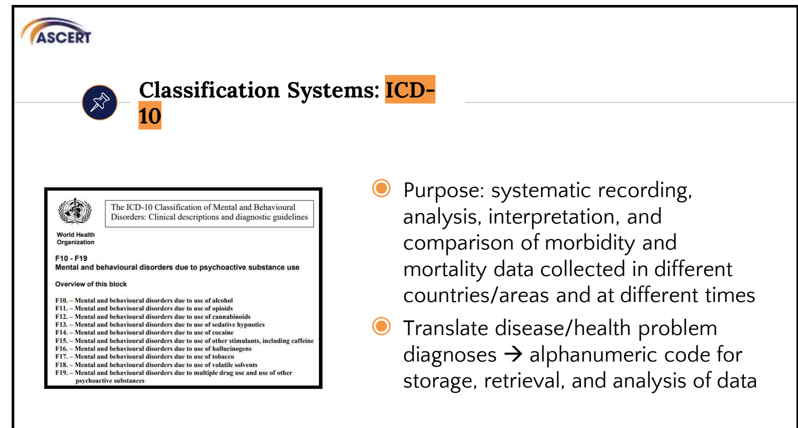

ASCERT
Housekeeping
Breaks
Microphones
Internet connections
Confidentiality

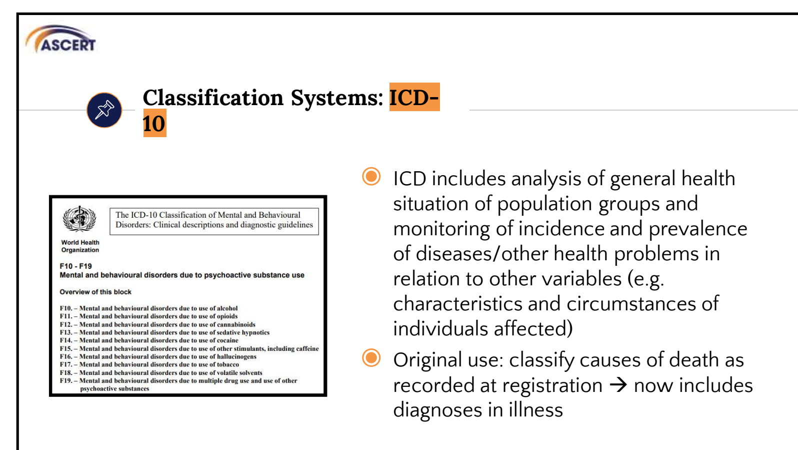

ASCERT
Course Objectives: Day Two
By the end of today, you will be able to:
Identify the two main classification systems that are relevant to mental health conditions
Identify common mental health conditions
Understand some treatment approaches, including NICE treatment guidelines, for some common mental health conditions

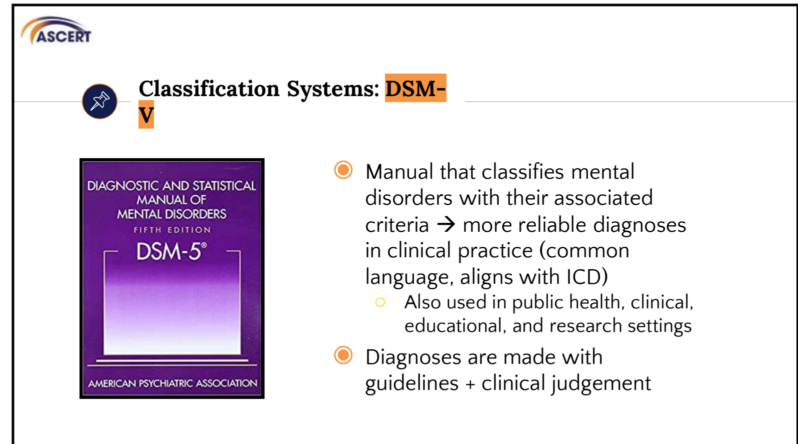

ASCERT
7
Introduction to the Classification of Mental Health Conditions
What are the ICD and DSM classification systems?

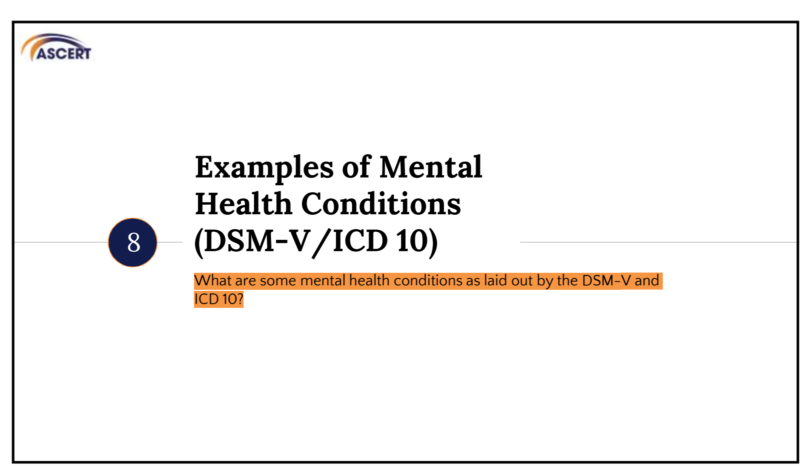

ASCERT
Classification Systems
ICD-10 (International Classification of Diseases, World Health Organization)
Codes from F00-F99
www.who.int/classifications/icd/en/bluebook.pdf
ICD-11 is due to come into effect in 2022
DSM-5 (Diagnostic and Statistical Manual, 5th edition, American Psychological Association)
Updated May 2013 – some significant changes
Did away with Multiaxial system (e.g. "Axis I Disorders"

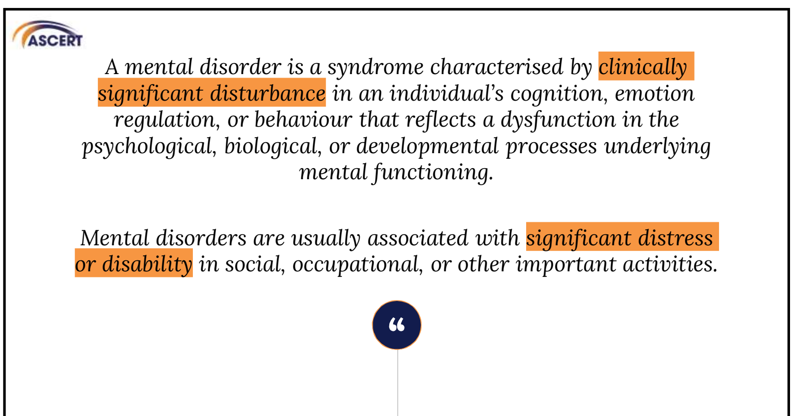

ASCERT
Classification Systems
ICD-10 vs. DSM-V
ICD-10 does have diagnostic guidelines but less in-depth compared to DSM
More focused on diagnostic coding, epidemiological use, billing/reimbursement
Covers other health conditions outside of mental health
Used internationally
DSM-V
Entirely focused on mental health conditions
Most popular in US but used to some degree here
DSM-5
ICD-10


ASCERT
Classification Systems: ICD-10
Purpose: systematic recording, analysis, interpretation, and comparison of morbidity and mortality data collected in different countries/areas and at different times
Translate disease/health problem diagnoses → alphanumeric code for storage, retrieval, and analysis of data


ASCERT
Classification Systems: ICD-10
ICD includes analysis of general health situation of population groups and monitoring of incidence and prevalence of diseases/other health problems in relation to other variables (e.g. characteristics and circumstances of individuals affected)
Original use: classify causes of death as recorded at registration → now includes diagnoses in illness


ASCERT
Classification Systems: DSM-V
DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS
FIFTH EDITION
DSM-5
AMERICAN PSYCHIATRIC ASSOCIATION
Manual that classifies mental disorders with their associated criteria → more reliable diagnoses in clinical practice (common language, aligns with ICD)
Also used in public health, clinical, educational, and research settings
Diagnoses are made with guidelines + clinical judgement


ASCERT
8
Examples of Mental Health Conditions (DSM-V/ICD 10)
What are some mental health conditions as laid out by the DSM-V and ICD 10?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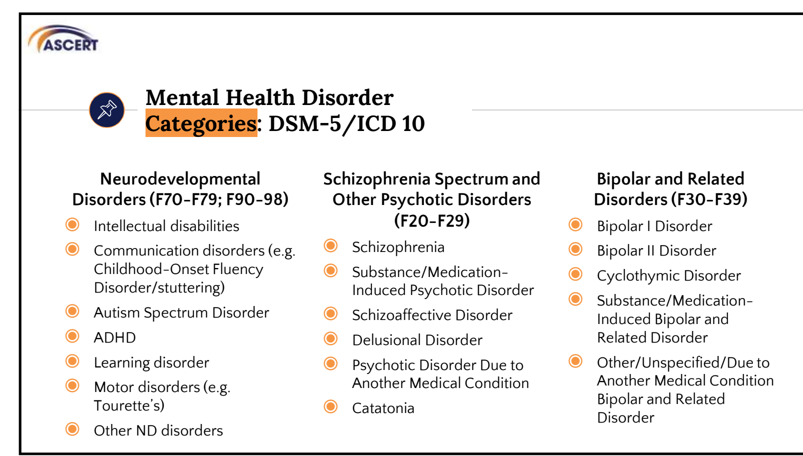
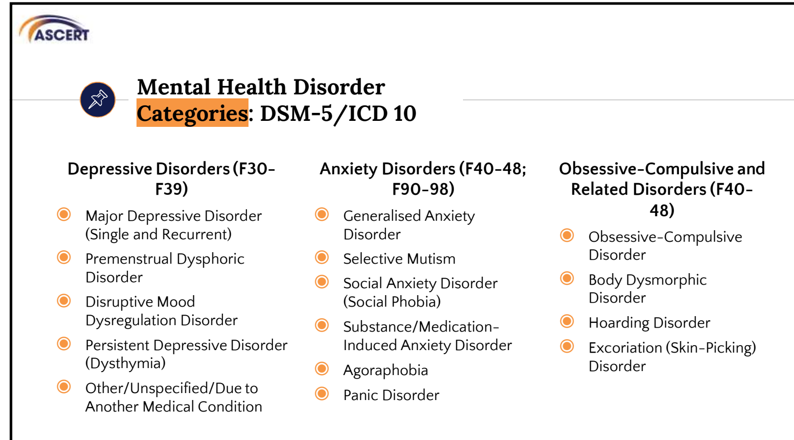
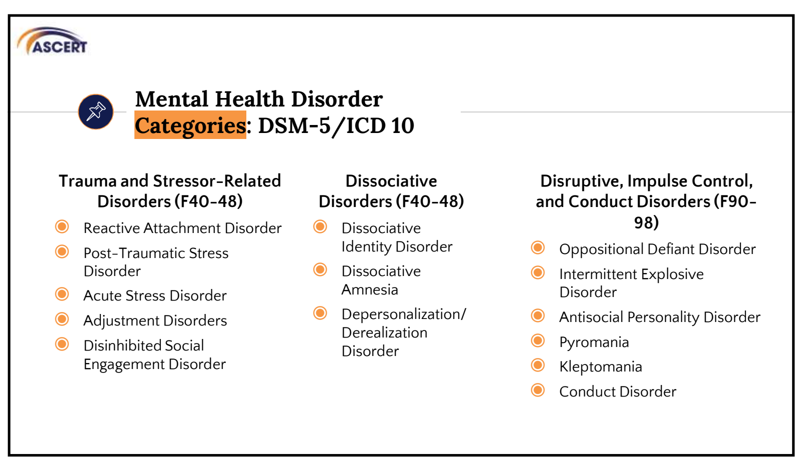
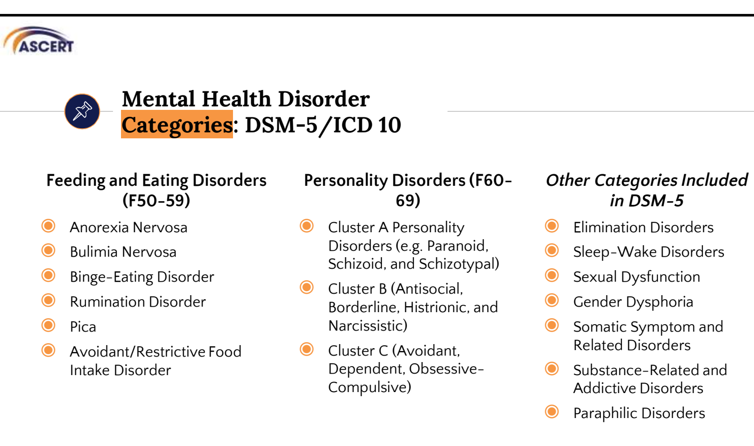
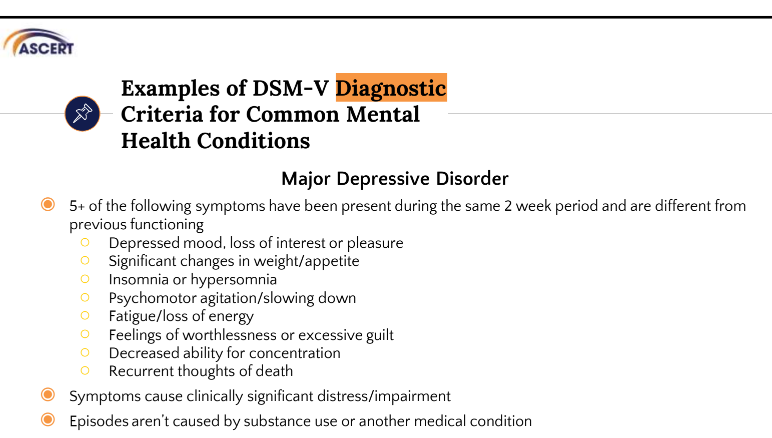
A mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.
Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.
American Psychological Association, DSM-V (p. 20)

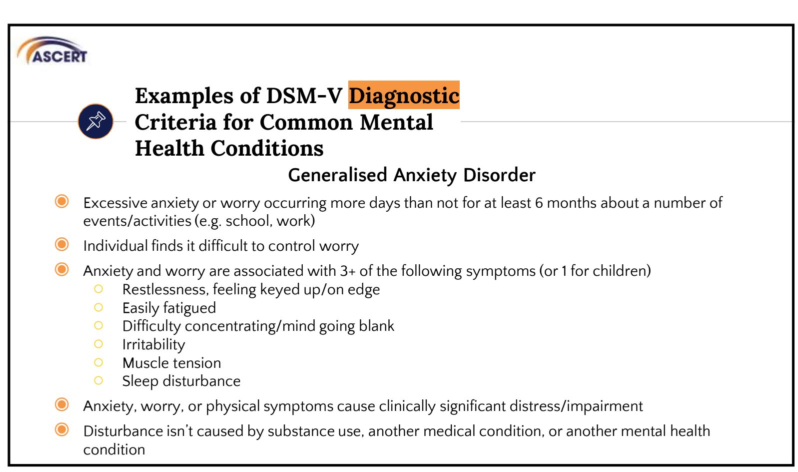

ASCERT
Mental Health Disorder Categories: DSM-5/ICD 10
Neurodevelopmental Disorders (F70-F79; F90-98)
Intellectual disabilities
Communication disorders (e.g. Childhood-Onset Fluency Disorder/stuttering)
Autism Spectrum Disorder
ADHD
Learning disorder
Motor disorders (e.g. Tourette's)
Other ND disorders
Schizophrenia Spectrum and Other Psychotic Disorders (F20-F29)
Schizophrenia
Substance/Medication-Induced Psychotic Disorder
Schizoaffective Disorder
Delusional Disorder
Psychotic Disorder Due to Another Medical Condition
Catatonia
Bipolar and Related Disorders (F30-F39)
Bipolar I Disorder
Bipolar II Disorder
Cyclothymic Disorder
Substance/Medication-Induced Bipolar and Related Disorder
Other/Unspecified/Due to Another Medical Condition Bipolar and Related Disorder

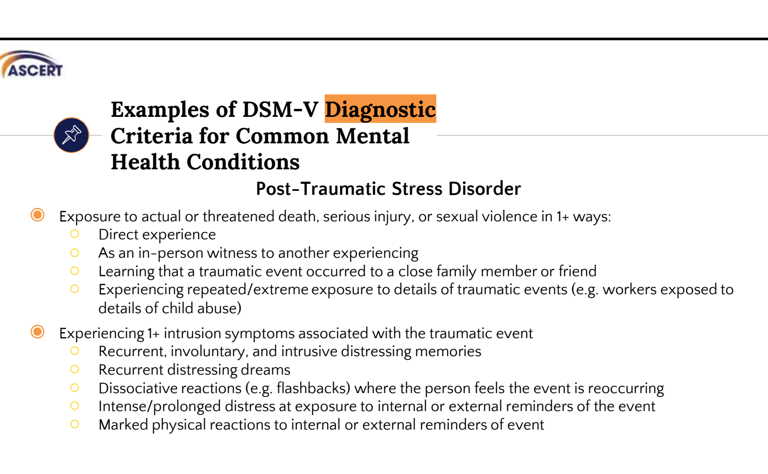

ASCERT
Mental Health Disorder Categories: DSM-5/ICD 10
Depressive Disorders (F30-F39)
Major Depressive Disorder (Single and Recurrent)
Premenstrual Dysphoric Disorder
Disruptive Mood Dysregulation Disorder
Persistent Depressive Disorder (Dysthymia)
Other/Unspecified/Due to Another Medical Condition
Anxiety Disorders (F40-48; F90-98)
Generalised Anxiety Disorder
Selective Mutism
Social Anxiety Disorder (Social Phobia)
Substance/Medication-Induced Anxiety Disorder
Agoraphobia
Panic Disorder
Obsessive-Compulsive and Related Disorders (F40-48)
Obsessive-Compulsive Disorder
Body Dysmorphic Disorder
Hoarding Disorder
Excoriation (Skin-Picking) Disorder

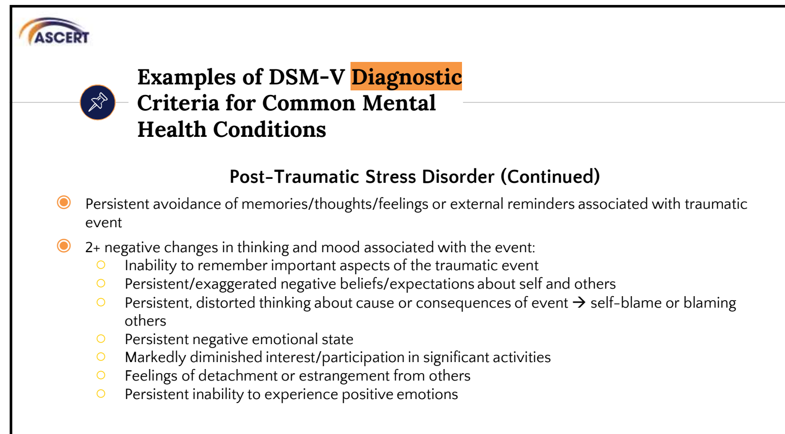

ASCERT
Mental Health Disorder Categories: DSM-5/ICD 10
Trauma and Stressor-Related Disorders (F40-48)
Reactive Attachment Disorder
Post-Traumatic Stress Disorder
Acute Stress Disorder
Adjustment Disorders
Disinhibited Social Engagement Disorder
Dissociative Disorders (F40-48)
Dissociative Identity Disorder
Dissociative Amnesia
Depersonalization/ Derealization Disorder
Disruptive, Impulse Control, and Conduct Disorders (F90-98)
Oppositional Defiant Disorder
Intermittent Explosive Disorder
Antisocial Personality Disorder
Pyromania
Kleptomania
Conduct Disorder

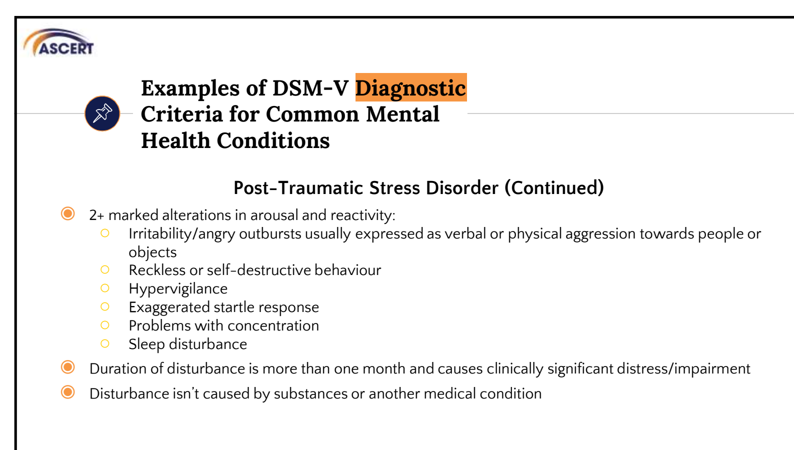

ASCERT
Mental Health Disorder Categories: DSM-5/ICD 10
Feeding and Eating Disorders (F50-59)
Anorexia Nervosa
Bulimia Nervosa
Binge-Eating Disorder
Rumination Disorder
Pica
Avoidant/Restrictive Food Intake Disorder
Personality Disorders (F60-69)
Cluster A Personality Disorders (e.g. Paranoid, Schizoid, and Schizotypal)
Cluster B (Antisocial, Borderline, Histrionic, and Narcissistic)
Cluster C (Avoidant, Dependent, Obsessive-Compulsive)
Other Categories Included in DSM-5
Elimination Disorders
Sleep-Wake Disorders
Sexual Dysfunction
Gender Dysphoria
Somatic Symptom and Related Disorders
Substance-Related and Addictive Disorders
Paraphilic Disorders

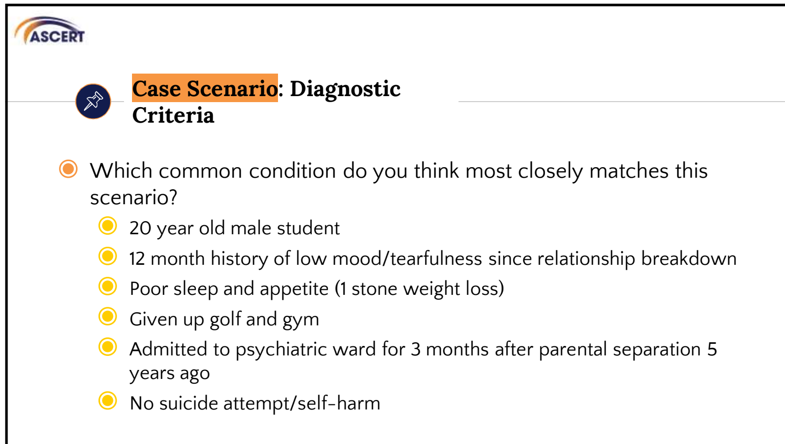

ASCERT
Examples of DSM-V Diagnostic Criteria for Common Mental Health Conditions
Major Depressive Disorder
5+ of the following symptoms have been present during the same 2 week period and are different from previous functioning
Depressed mood, loss of interest or pleasure
Significant changes in weight/appetite
Insomnia or hypersomnia
Psychomotor agitation/slowing down
Fatigue/loss of energy
Feelings of worthlessness or excessive guilt
Decreased ability for concentration
Recurrent thoughts of death
Symptoms cause clinically significant distress/impairment
Episodes aren't caused by substance use or another medical condition

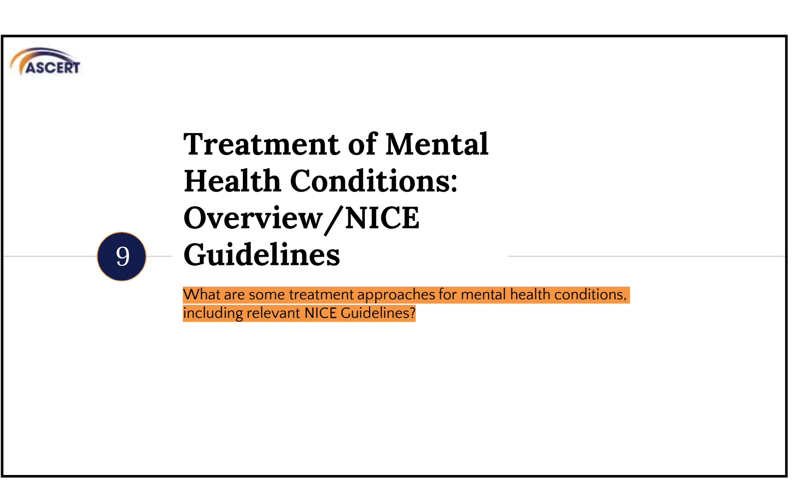

ASCERT
Examples of DSM-V Diagnostic Criteria for Common Mental Health Conditions
Generalised Anxiety Disorder
Excessive anxiety or worry occurring more days than not for at least 6 months about a number of events/activities (e.g. school, work)
Individual finds it difficult to control worry
Anxiety and worry are associated with 3+ of the following symptoms (or 1 for children)
Restlessness, feeling keyed up/on edge
Easily fatigued
Difficulty concentrating/mind going blank
Irritability
Muscle tension
Sleep disturbance
Anxiety, worry, or physical symptoms cause clinically significant distress/impairment
Disturbance isn't caused by substance use, another medical condition, or another mental health condition

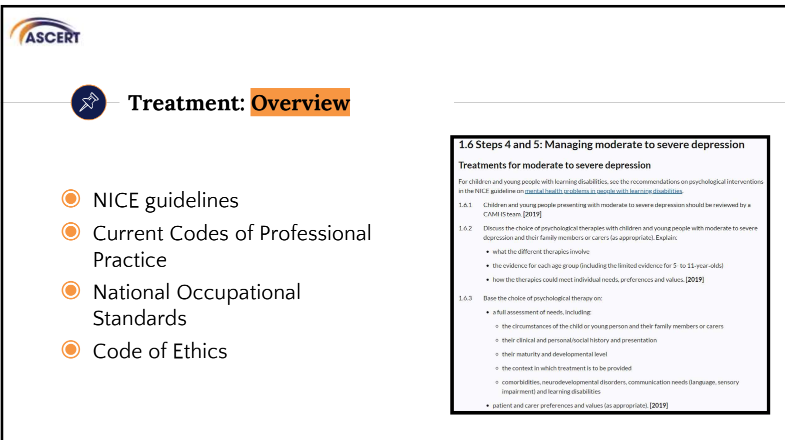

ASCERT
Examples of DSM-V Diagnostic Criteria for Common Mental Health Conditions
Post-Traumatic Stress Disorder
Exposure to actual or threatened death, serious injury, or sexual violence in 1+ ways:
Direct experience
As an in-person witness to another experiencing
Learning that a traumatic event occurred to a close family member or friend
Experiencing repeated/extreme exposure to details of traumatic events (e.g. workers exposed to details of child abuse)
Experiencing 1+ intrusion symptoms associated with the traumatic event
Recurrent, involuntary, and intrusive distressing memories
Recurrent distressing dreams
Dissociative reactions (e.g. flashbacks) where the person feels the event is reoccurring
Intense/prolonged distress at exposure to internal or external reminders of the event
Marked physical reactions to internal or external reminders of event

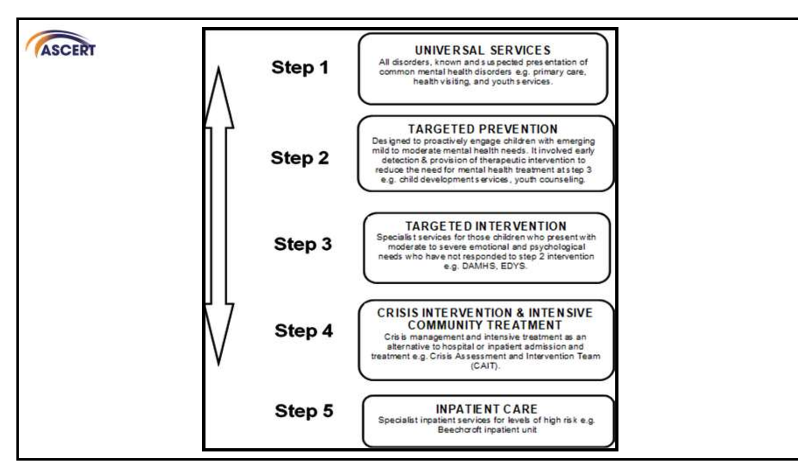

ASCERT
Examples of DSM-V Diagnostic Criteria for Common Mental Health Conditions
Post-Traumatic Stress Disorder (Continued)
Persistent avoidance of memories/thoughts/feelings or external reminders associated with traumatic event
2+ negative changes in thinking and mood associated with the event:
Inability to remember important aspects of the traumatic event
Persistent/exaggerated negative beliefs/expectations about self and others
Persistent, distorted thinking about cause or consequences of event → self-blame or blaming others
Persistent negative emotional state
Markedly diminished interest/participation in significant activities
Feelings of detachment or estrangement from others
Persistent inability to experience positive emotions

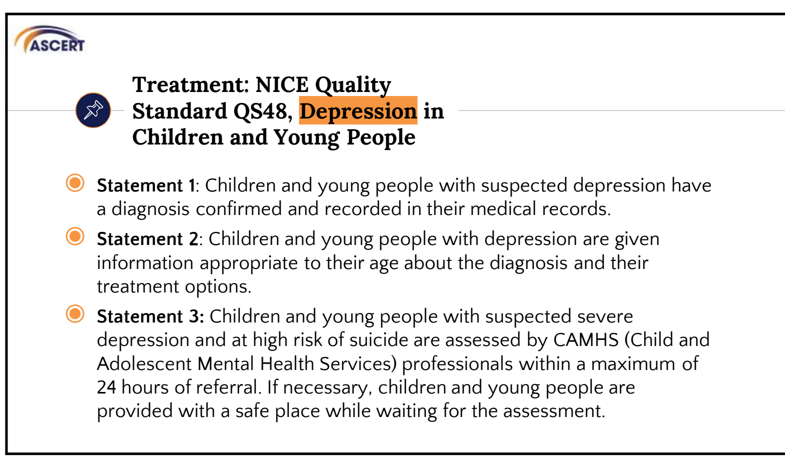

ASCERT
Examples of DSM-V Diagnostic Criteria for Common Mental Health Conditions
Post-Traumatic Stress Disorder (Continued)
2+ marked alterations in arousal and reactivity:
Irritability/angry outbursts usually expressed as verbal or physical aggression towards people or objects
Reckless or self-destructive behaviour
Hypervigilance
Exaggerated startle response
Problems with concentration
Sleep disturbance
Duration of disturbance is more than one month and causes clinically significant distress/impairment
Disturbance isn't caused by substances or another medical condition


ASCERT
Case Scenario: Diagnostic Criteria
Which common condition do you think most closely matches this scenario?
20 year old male student
12 month history of low mood/tearfulness since relationship breakdown
Poor sleep and appetite (1 stone weight loss)
Given up golf and gym
Admitted to psychiatric ward for 3 months after parental separation 5 years ago
No suicide attempt/self-harm


ASCERT
Treatment of Mental Health Conditions: Overview/NICE Guidelines
9
What are some treatment approaches for mental health conditions, including relevant NICE Guidelines?


ASCERT
Treatment: Overview
NICE guidelines
Current Codes of Professional Practice
National Occupational Standards
Code of Ethics
1.6 Steps 4 and 5: Managing moderate to severe depression
Treatments for moderate to severe depression
For children and young people with learning disabilities, see the recommendations on psychological interventions in the NICE guideline on mental health problems in people with learning disabilities.
1.6.1 Children and young people presenting with moderate to severe depression should be reviewed by a CAMHS team. [2019]
1.6.2 Discuss the choice of psychological therapies with children and young people with moderate to severe depression and their family members or carers (as appropriate). Explain:
what the different therapies involve
the evidence for each age group (including the limited evidence for 5- to 11-year-olds)
how the therapies could meet individual needs, preferences and values. [2019]
1.6.3 Base the choice of psychological therapy on:
a full assessment of needs, including:
the circumstances of the child or young person and their family members or carers
their clinical and personal/social history and presentation
their maturity and developmental level
the context in which treatment is to be provided
comorbidities, neurodevelopmental disorders, communication needs (language, sensory impairment) and learning disabilities
patient and carer preferences and values (as appropriate). [2019]


ASCERT
Step 1
UNIVERSAL SERVICES
All disorders, known and suspected presentation of common mental health disorders e.g. primary care, health visiting, and youth services.
Step 2
TARGETED PREVENTION
Designed to proactively engage children with emerging mild to moderate mental health needs. It involved early detection & provision of therapeutic intervention to reduce the need for mental health treatment at step 3 e.g. child development services, youth counseling.
Step 3
TARGETED INTERVENTION
Specialist services for those children who present with moderate to severe emotional and psychological needs who have not responded to step 2 intervention e.g. DAMHS, EDYS.
Step 4
CRISIS INTERVENTION & INTENSIVE COMMUNITY TREATMENT
Crisis management and intensive treatment as an alternative to hospital or inpatient admission and treatment e.g. Crisis Assessment and Intervention Team (CAIT).
Step 5
INPATIENT CARE
Specialist inpatient services for levels of high risk e.g. Beechcroft inpatient unit


ASCERT
Treatment: NICE Quality Standard QS48, Depression in Children and Young People
Statement 1: Children and young people with suspected depression have a diagnosis confirmed and recorded in their medical records.
Statement 2: Children and young people with depression are given information appropriate to their age about the diagnosis and their treatment options.
Statement 3: Children and young people with suspected severe depression and at high risk of suicide are assessed by CAMHS (Child and Adolescent Mental Health Services) professionals within a maximum of 24 hours of referral. If necessary, children and young people are provided with a safe place while waiting for the assessment.

ASCERT
Treatment: NICE Quality Standard QS48, Depression in Children and Young People
Statement 4: Children and young people with suspected severe depression but not at high risk of suicide are assessed by CAMHS (Child and Adolescent Mental Health Services) professionals within a maximum of 2 weeks of referral
Statement 5: Children and young people receiving treatment for depression have their health outcomes recorded at the beginning and end of each step in treatment.

Treatment: NICE Quality Standard QS53, Anxiety Disorders

- **Statement 1:** People with a suspected anxiety disorder receive an assessment that identifies whether they have a specific anxiety disorder, the severity of symptoms and associated functional impairment.
- **Statement 2:** People with an anxiety disorder are offered evidence-based psychological interventions.
- **Statement 3:** People with an anxiety disorder are not prescribed benzodiazepines or antipsychotics unless specifically indicated.
- **Statement 4:** People receiving treatment for an anxiety disorder have their response to treatment recorded at each treatment session.

Treatment: NICE Quality Statement, Anxiety Disorders

Examples of Anxiety Disorders

- Generalised Anxiety Disorder
- Social Anxiety Disorder
- Post-Traumatic Stress Disorder
- Panic Disorder
- Obsessive-Compulsive Disorder
- Body Dysmorphic Disorder

Components of Assessment

- Nature, duration, and severity of the presenting disorder
- Associated functional impairment
- Consideration of the ways in which the relevant factors may have affected the development, course, and severity of the disorder

Treatment: NICE Clinical Guidelines for Assessment, Anxiety Disorders

- History of any mental health disorder
- History of a chronic physical health problem
- Any past experience of, and response to, treatments
- The quality of interpersonal relationships

[NICE clinical guideline 123, recommendations 1.3.2.4 and 1.3.2.6]

Treatment: NICE Clinical Guidelines for Assessment, Anxiety Disorders

- Living conditions and social isolation
- Family history of mental illness
- History of domestic violence or sexual abuse
- Employment and immigration status

[NICE clinical guideline 123, recommendations 1.3.2.4 and 1.3.2.6]

Treatment: Evidence-Based Psychological Interventions, Anxiety Disorders

- Evidence-based psychological interventions include both low-intensity interventions incorporating self-help approaches and high-intensity psychological therapies
- For adults with Generalized Anxiety Disorder, Panic Disorder, Post-Traumatic Stress Disorder, Obsessive-Compulsive Disorder or Body Dysmorphic Disorder, psychological interventions are offered based on the stepped-care approach
  - NICE clinical guideline 123, recommendation 1.4.1.4

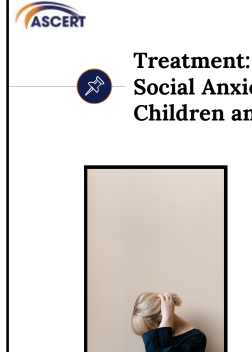
Treatment: Evidence-Based Psychological Interventions, Anxiety Disorders

- Cognitive Behavioural Therapy has been specifically developed to treat Social Anxiety Disorder in adults, children and young people
  - NICE clinical guideline 159, recommendations 1.3.2 and 1.5.3
- Psychological therapies have been specifically developed to treat Obsessive-Compulsive Disorder, Body Dysmorphic Disorder and Post-Traumatic Stress Disorder in children and young people.
  - NICE clinical guideline 31, recommendations 1.5.1.9 and 1.5.1.10.
  - NICE clinical guideline 26, recommendation 1.9.5

Treatment: Importance of Social Anxiety

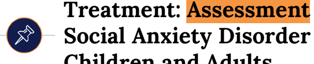
- For some disorders, including Avoidant Personality Disorder, alcohol and substance misuse, mood disorders, other anxiety disorders, psychosis, and autism, it is important to record a detailed description of the person's current social anxiety and associated problems and circumstances including:
  - Feared and avoided social situations
  - What they are afraid might happen in social situations (for example, looking anxious, blushing, sweating, trembling or appearing boring)
  - Anxiety symptoms
  - View of self

Treatment: Assessment of Social Anxiety Disorder in Children and Adults



- Safety-seeking behaviours
- Focus of attention in social situations
- Anticipatory and post-event processing
- Occupational, educational, financial and social circumstances

[NICE clinical guideline 159, recommendations 1.2.5 to 1.2.9 and 1.4.5 to 1.4.8]



Treatment: Assessment of Social Anxiety Disorder in Children and Adults

- Family circumstances and support (for children and young people)
- Friendships and peer groups (for children and young people)
- Medication, alcohol and recreational drug use

[NICE clinical guideline 159, recommendations 1.2.5 to 1.2.9 and 1.4.5 to 1.4.8]

Treatment: Interventions That Are Not Recommended by NICE for Social Anxiety Disorder

- 1.6.1 Do not routinely offer pharmacological interventions to treat social anxiety disorder in children and young people.
- 1.6.2 Do not routinely offer anticonvulsants, tricyclic antidepressants, benzodiazepines or antipsychotic medication to treat social anxiety disorder in adults.

Treatment: Interventions That Are Not Recommended by NICE for Social Anxiety Disorder

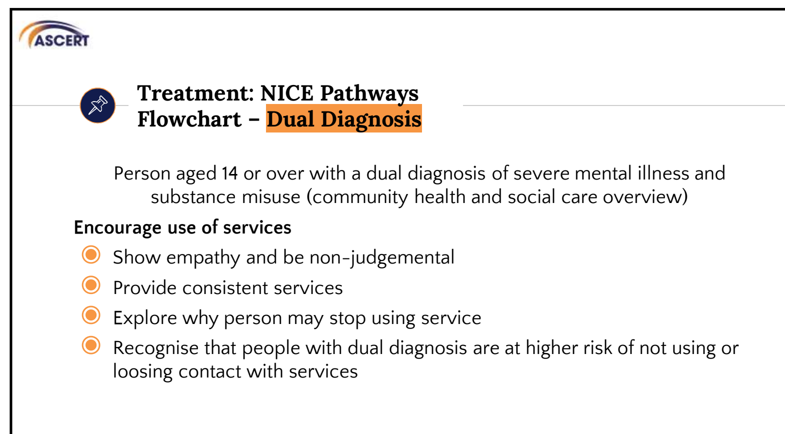
- 1.6.3 Do not routinely offer mindfulness-based interventions or supportive therapy to treat Social Anxiety Disorder.
- 1.6.4 Do not offer St John's Wort or other over-the-counter medications and preparations for anxiety to treat Social Anxiety Disorder. Explain the potential interactions with other prescribed and over-the-counter medications and the lack of evidence to support their safe use.

Treatment: NICE Pathways Flowchart – Dual Diagnosis

Person aged 14 or over with a dual diagnosis of severe mental illness and substance misuse (community health and social care overview)

First contact and referral

- Aim to meet their immediate needs, wherever they present
- Be aware of possible chronic physical health conditions
- Peoples' unmet needs may lead to relapse
- Safeguarding needs
- Referral into secondary care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Treatment: NICE Pathways
Flowchart – Dual Diagnosis
Person aged 14 or over with a dual diagnosis of severe mental illness and substance misuse (community health and social care overview)
Encourage use of services
Show empathy and be non-judgemental
Provide consistent services
Explore why person may stop using service
Recognise that people with dual diagnosis are at higher risk of not using or loosing contact with services

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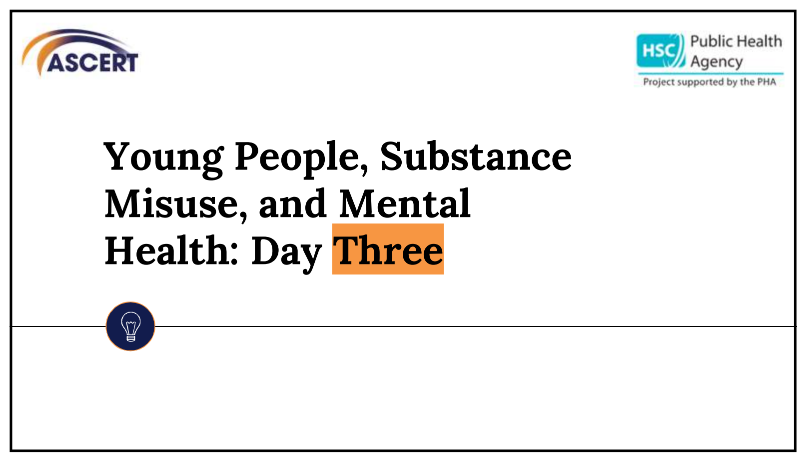
End of Day Two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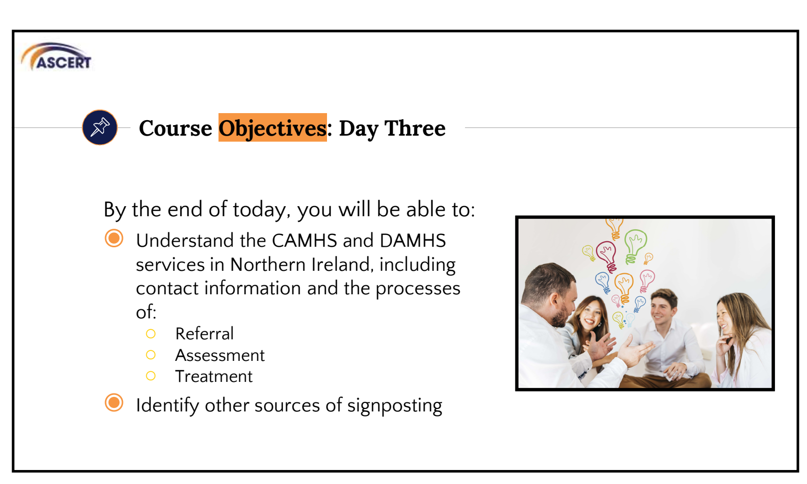
HSC Public Health Agency
Project supported by the PHA
Young People, Substance Misuse, and Mental Health: Day Three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Course Objectives: Day Three
By the end of today, you will be able to:
Understand the CAMHS and DAMHS services in Northern Ireland, including contact information and the processes of:
Referral
Assessment
Treatment
Identify other sources of signposting

Treatment of Mental Health Conditions: CAMHS and DAMHS

What is CAMHS and DAMHS, and how do they work?

Treatment: CAMHS

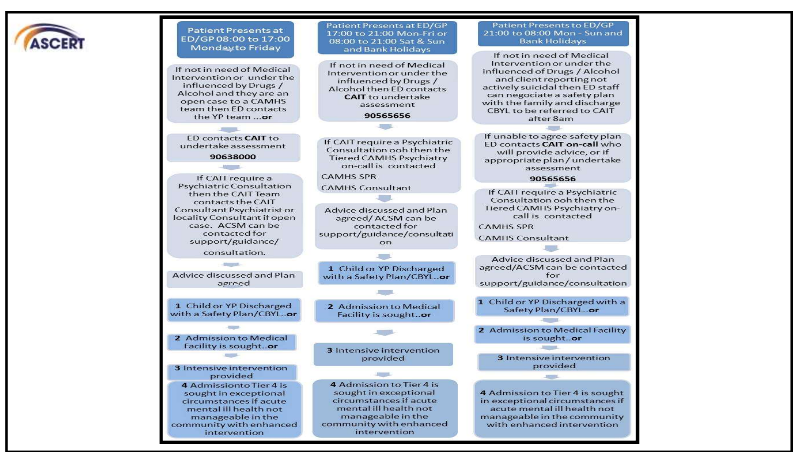
- The Child and Adolescent Mental Health Service aims to promote emotional well-being and deliver care, treatment and preventative mental health services to children and young people aged 0 – 18 years of age who experience significant mental health difficulties.
- The service works in many different ways with children and young people, depending on their needs
- The CAMHS teams employ specialist mental health workers (for example Clinical Nurse Specialists, Mental Health Social Workers, Consultant Psychiatrists, Clinical Psychologists, Family Therapists) to work with children and young people who have complex mental health needs. The professionals also provide support to parents and carers.

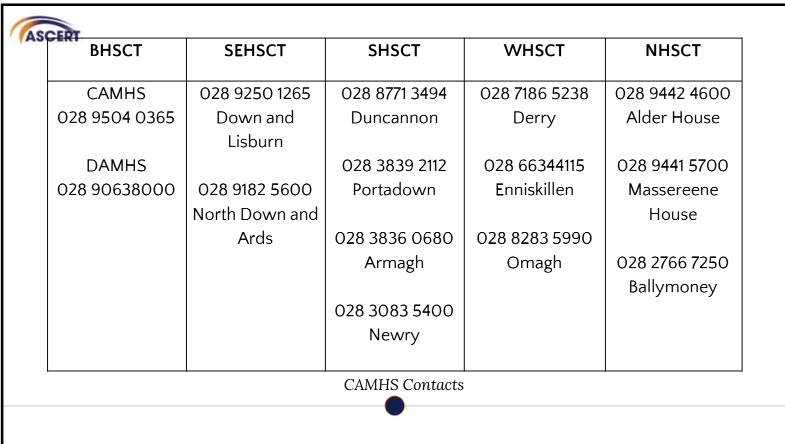
Treatment: CAMHS Special Interest Teams

- CAMHS also work with and support children and young people who may need very specialist treatment from services such as:
  - The Eating Disorder Service
  - Crisis Assessment Intervention Team And Intensive Intervention Treatment (CAIT Beechcroft Hospital)
  - The Drug And Alcohol Mental Health Service (D.A.M.H.S. Beechcroft Hospital)
  - Know Our Identity Team (K.O. I .- R. V. H. AND Beechcroft Hospital)
  - Generic CAMHS Treatment Team (The Young People's Centre, R.V.H, Lagan Valley Hospital and Newtownards)
- Where necessary, these teams refer children and young people who may need a stay in hospital for intensive care, support and treatment, to the Adolescences Mental Health Service (A.M.H.S.) at Beechcroft Hospital

Treatment: CAMHS Special Interest Teams

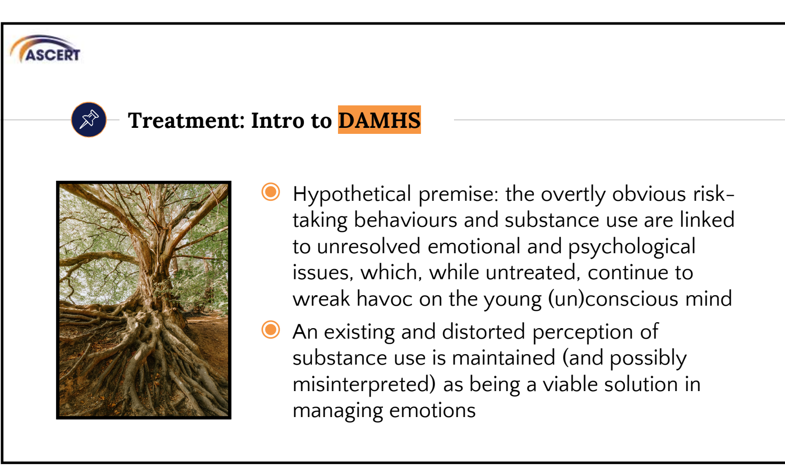
- CAMHS also work with and support children and young people who may need very specialist treatment from services such as:
  - The Eating Disorder Service (Alder House, Antrim Area Hospital)
  - Crisis Team (Out of Hours Dal-Doc system; A&E Antrim Area and Causeway Hospitals)
  - The Drug And Alcohol Mental Health Service
  - CAMHS Systemic and Family Psychotherapy Service
  - CAMHS Psychoanalytic Psychotherapy Service

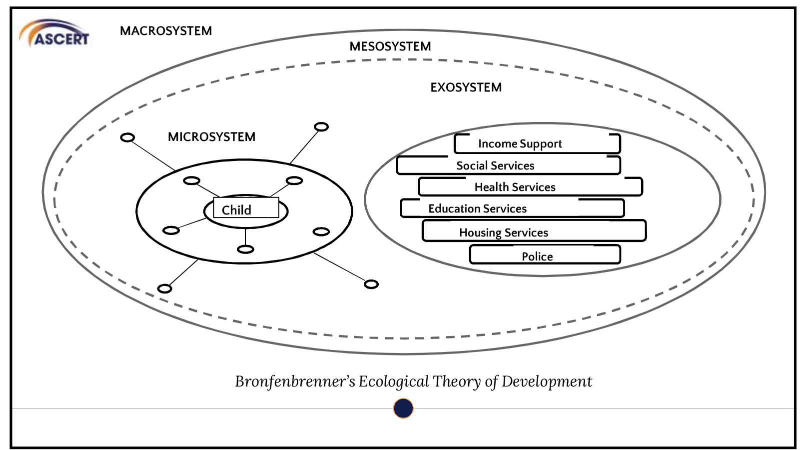




BHSCT	SEHSCT	SHSCT	WHSCT	NHSCT
CAMHS 028 9504 0365	028 9250 1265 Down and Lisburn	028 8771 3494 Duncannon	028 7186 5238 Derry	028 9442 4600 Alder House
DAMHS 028 90638000	028 9182 5600 North Down and Ards	028 3839 2112 Portadown	028 66344115 Enniskillen	028 9441 5700 Massereene House
		028 3836 0680 Armagh	028 8283 5990 Omagh	028 2766 7250 Ballymoney
		028 3083 5400 Newry		

CAMHS Contacts

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MACROSYSTEM
MESOSYSTEM
EXOSYSTEM
MICROSYSTEM
Child
Income Support
Social Services
Health Services
Education Services
Housing Services
Police
Bronfenbrenner's Ecological Theory of Development

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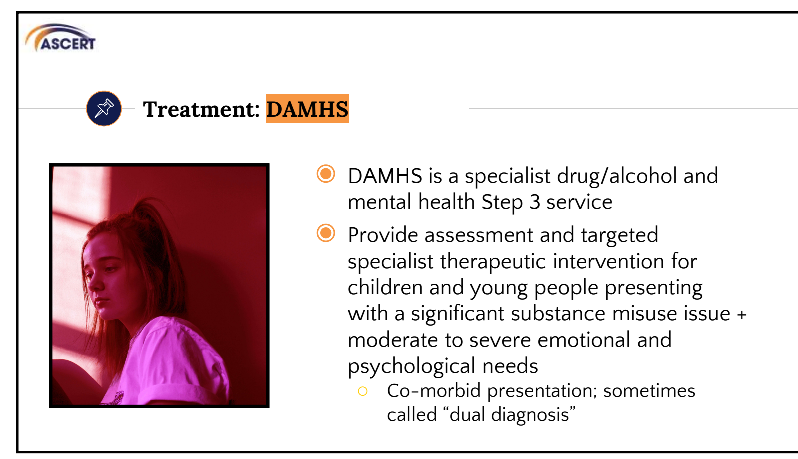
How do you think technology may impact upon this theoretical construct, positively or negatively?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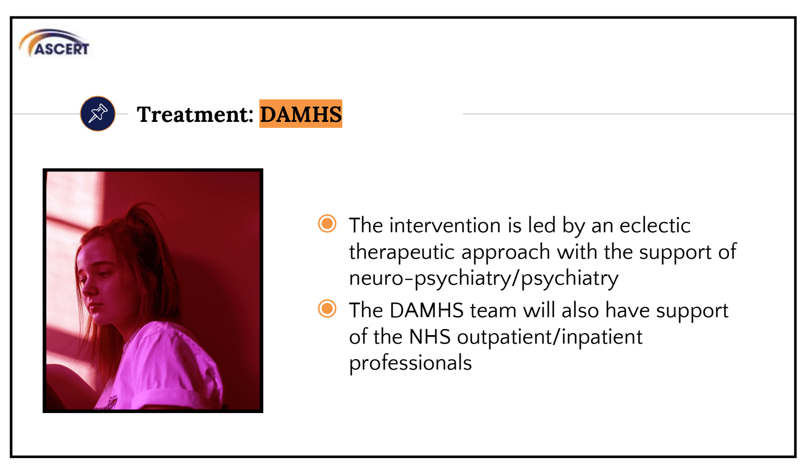
Treatment: DAMHS
DAMHS is a specialist drug/alcohol and mental health Step 3 service
Provide assessment and targeted specialist therapeutic intervention for children and young people presenting with a significant substance misuse issue + moderate to severe emotional and psychological needs
Co-morbid presentation; sometimes called "dual diagnosis"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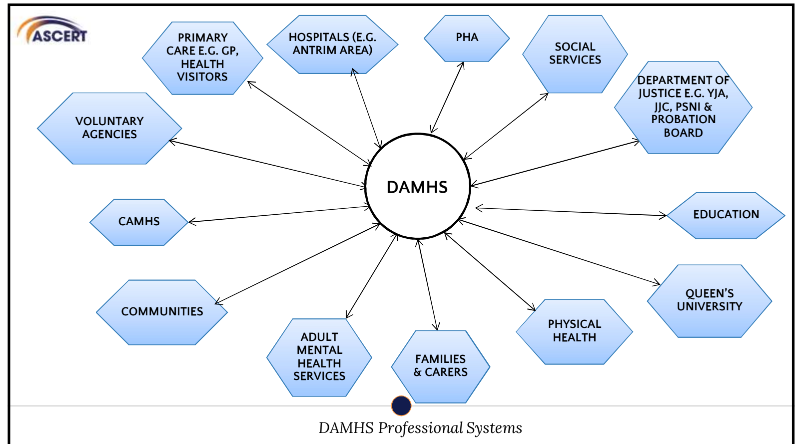
Treatment: DAMHS
The intervention is led by an eclectic therapeutic approach with the support of neuro-psychiatry/psychiatry
The DAMHS team will also have support of the NHS outpatient/inpatient professionals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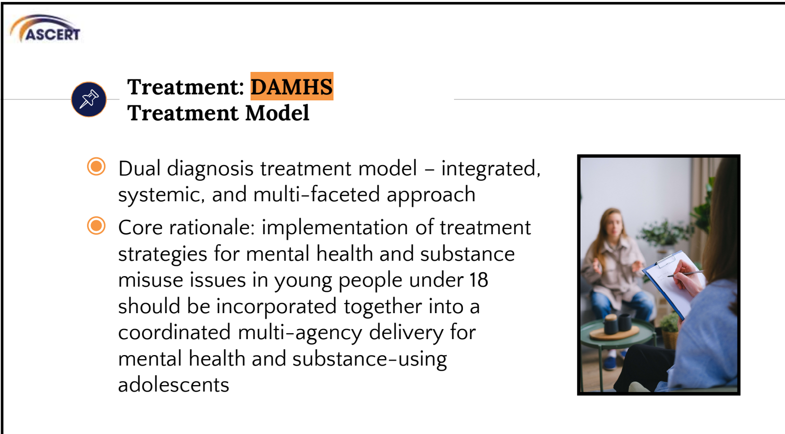
PRIMARY CARE E.G. GP, HEALTH VISITORS
HOSPITALS (E.G. ANTRIM AREA)
PHA
SOCIAL SERVICES
DEPARTMENT OF JUSTICE E.G. YJA, JJC, PSNI & PROBATION BOARD
VOLUNTARY AGENCIES
DAMHS
CAMHS
EDUCATION
COMMUNITIES
QUEEN'S UNIVERSITY
PHYSICAL HEALTH
ADULT MENTAL HEALTH SERVICES
FAMILIES & CARERS
DAMHS Professional Systems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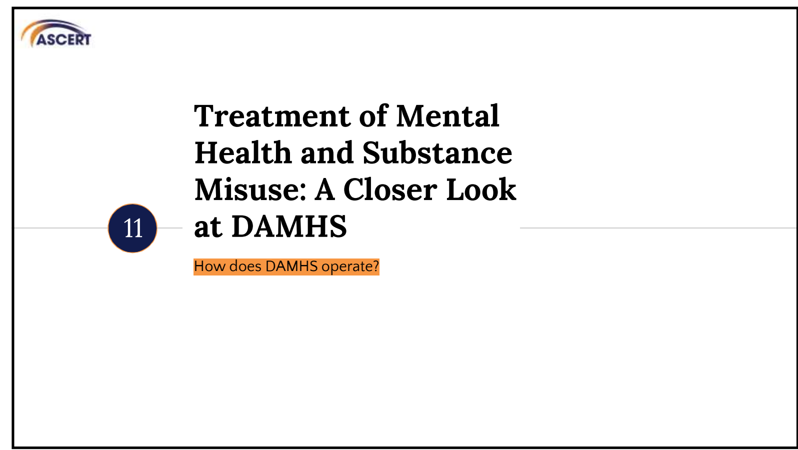
Treatment: DAMHS
Treatment Model
Dual diagnosis treatment model – integrated, systemic, and multi-faceted approach
Core rationale: implementation of treatment strategies for mental health and substance misuse issues in young people under 18 should be incorporated together into a coordinated multi-agency delivery for mental health and substance-using adolescents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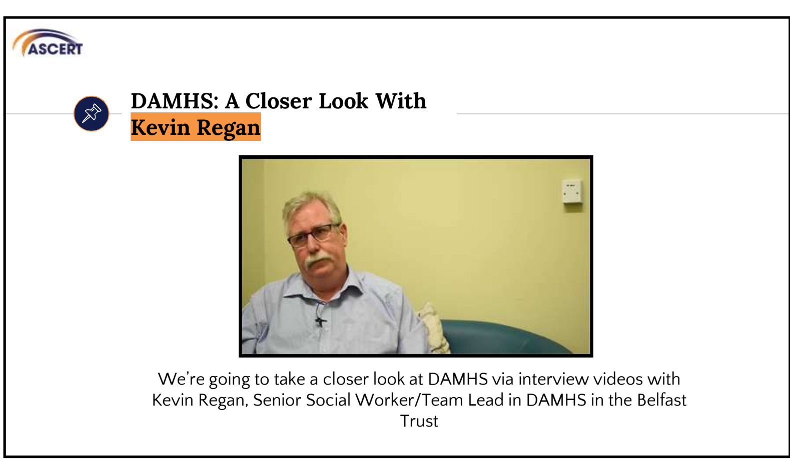
11
Treatment of Mental Health and Substance Misuse: A Closer Look at DAMHS
How does DAMHS operate?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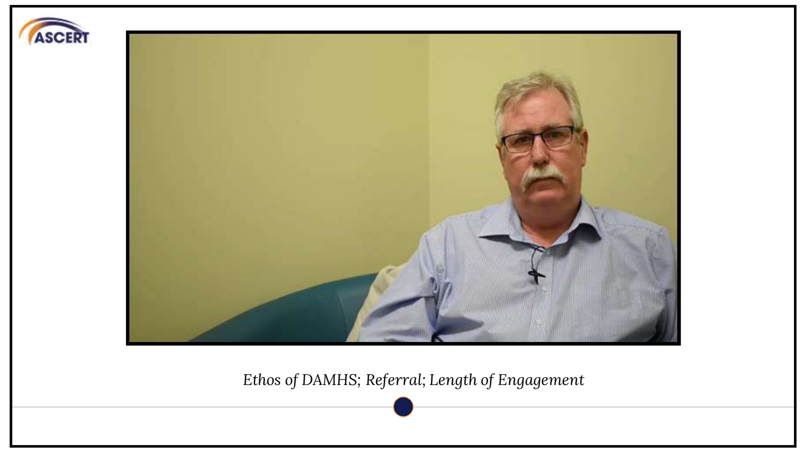
DAMHS: A Closer Look With
Kevin Regan
We're going to take a closer look at DAMHS via interview videos with Kevin Regan, Senior Social Worker/Team Lead in DAMHS in the Belfast Trust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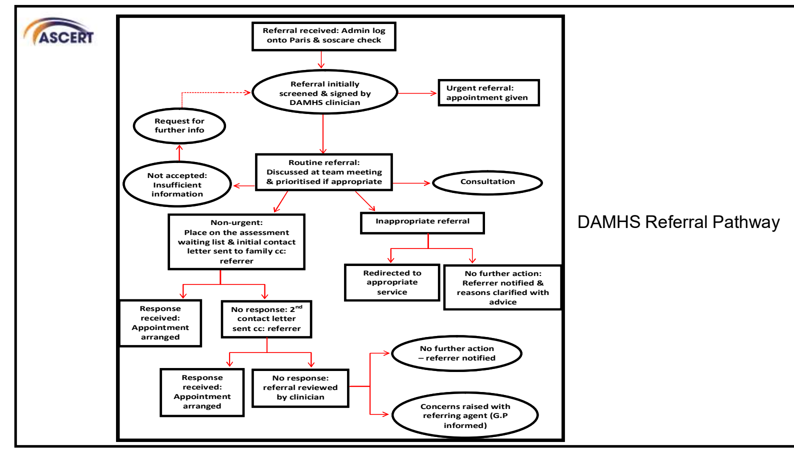
Ethos of DAMHS; Referral; Length of Engagement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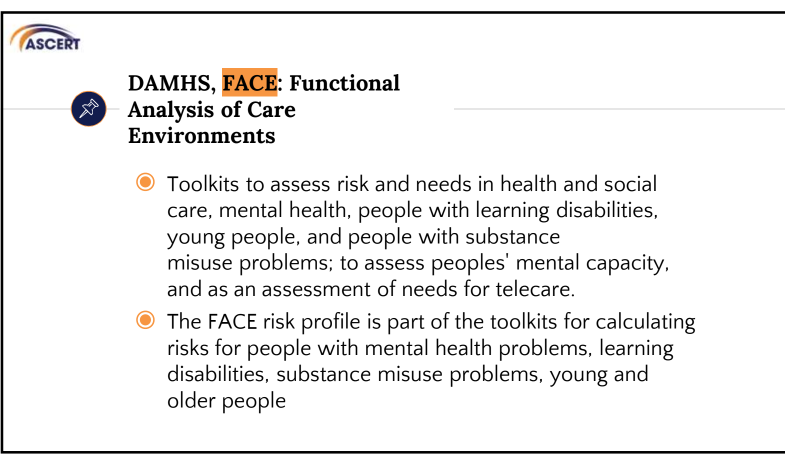
Referral received: Admin log onto Paris & soscare check
Referral initially screened & signed by DAMHS clinician
Urgent referral: appointment given
Request for further info
Routine referral: Discussed at team meeting & prioritised if appropriate
Not accepted: Insufficient information
Consultation
Non-urgent: Place on the assessment waiting list & initial contact letter sent to family cc: referrer
Inappropriate referral
Redirected to appropriate service
No further action: Referrer notified & reasons clarified with advice
Response received: Appointment arranged
No response: 2nd contact letter sent cc: referrer
No further action – referrer notified
Response received: Appointment arranged
No response: referral reviewed by clinician
Concerns raised with referring agent (G.P informed)
DAMHS Referral Pathway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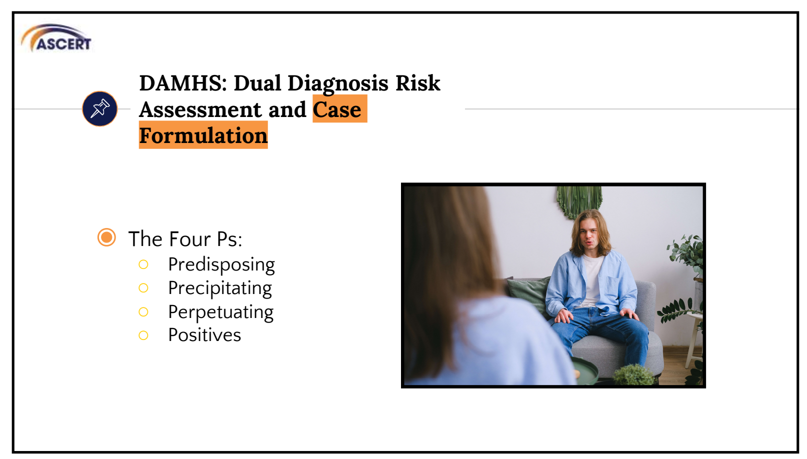
DAMHS, FACE: Functional Analysis of Care Environments
Toolkits to assess risk and needs in health and social care, mental health, people with learning disabilities, young people, and people with substance misuse problems; to assess peoples' mental capacity, and as an assessment of needs for telecare.
The FACE risk profile is part of the toolkits for calculating risks for people with mental health problems, learning disabilities, substance misuse problems, young and older people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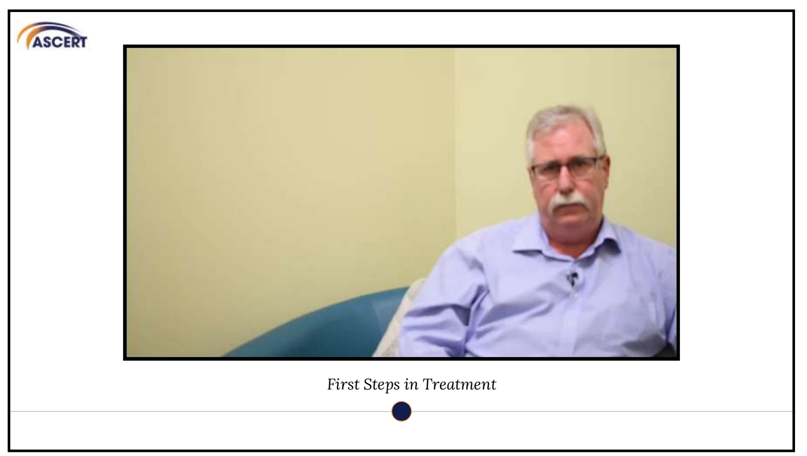
DAMHS: Dual Diagnosis Risk Assessment and Case Formulation
The Four Ps:
Predisposing
Precipitating
Perpetuating
Positives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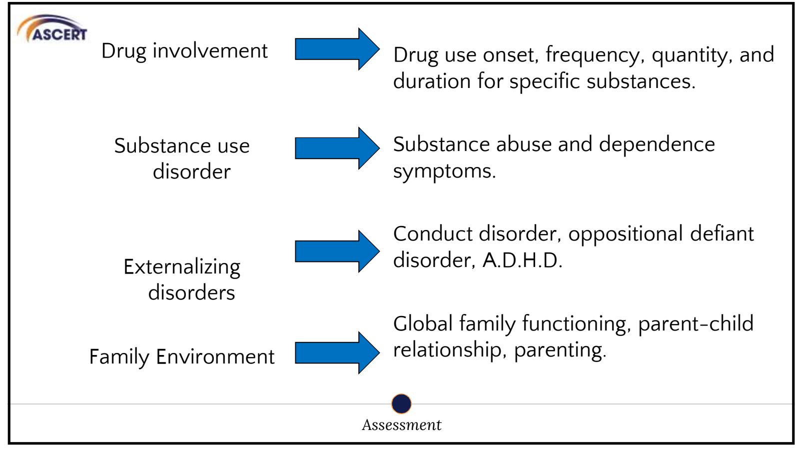
First Steps in Treatment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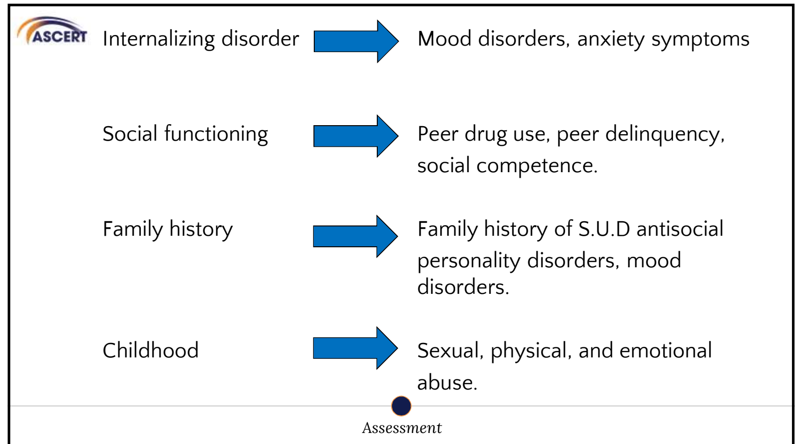
Drug involvement
Drug use onset, frequency, quantity, and duration for specific substances.
Substance use disorder
Substance abuse and dependence symptoms.
Externalizing disorders
Conduct disorder, oppositional defiant disorder, A.D.H.D.
Family Environment
Global family functioning, parent-child relationship, parenting.
Assessment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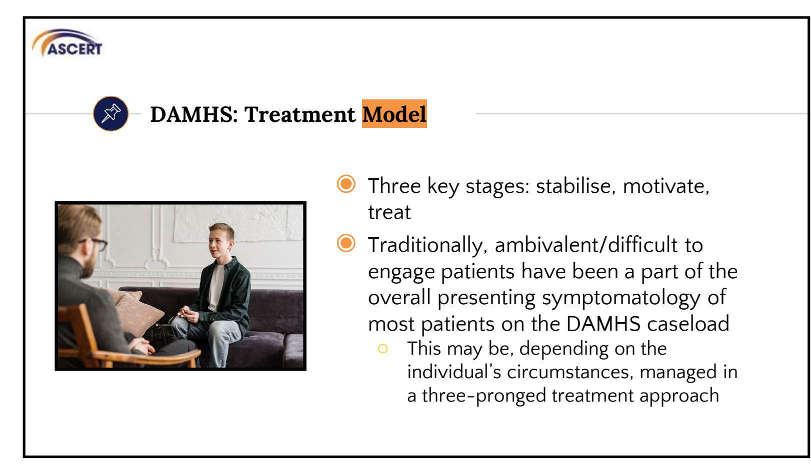
Internalizing disorder
Mood disorders, anxiety symptoms
Social functioning
Peer drug use, peer delinquency, social competence.
Family history
Family history of S.U.D antisocial personality disorders, mood disorders.
Childhood
Sexual, physical, and emotional abuse.
Assessment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DAMHS: Treatment Model
Three key stages: stabilise, motivate, treat
Traditionally, ambivalent/difficult to engage patients have been a part of the overall presenting symptomatology of most patients on the DAMHS caseload
This may be, depending on the individual's circumstances, managed in a three-pronged treatment approach

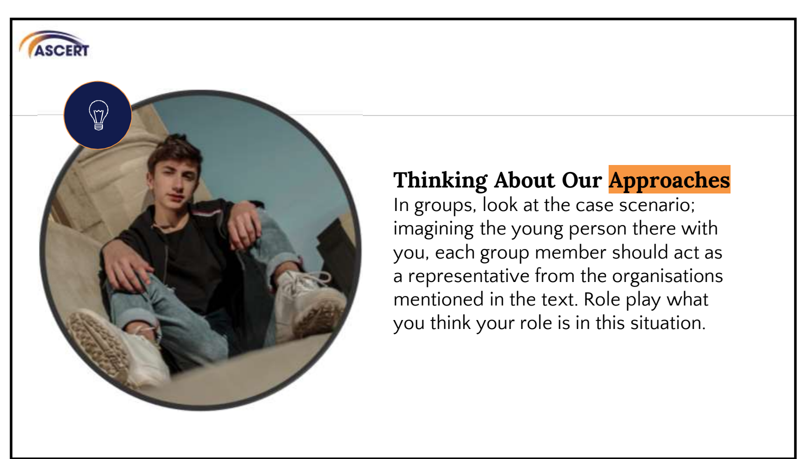
DAMHS: Treatment Approaches

- Schemata-based Cognitive Behavioural Psychotherapy
  - Schema = cognitive framework that helps organise and interpret information in the world around us
  - Used to treat substance misuse and mental health problems
  - Goal = help clients identify maladaptive thoughts, feelings, and behaviours that maintain or exacerbate presenting difficulties
  - Allows service user to develop a skill set which offers a feasible alternative to managing emotional and psychological difficulties without the use of previous safety behaviours

DAMHS: Treatment Approaches

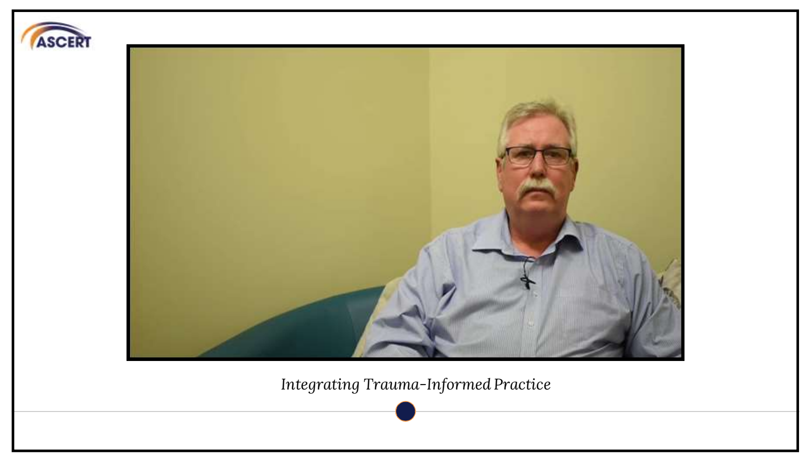
- Motivational Interviewing
  - Approach to working with ambivalent clients to reduce resistance to change and promote self-efficacy
- Pharmacology/psychiatry
  - Medication may also be used alongside cognitive interventions
- Family work
  - Most of the families require a great deal of support and work (e.g. family therapeutic groups)

Approaches and Interventions

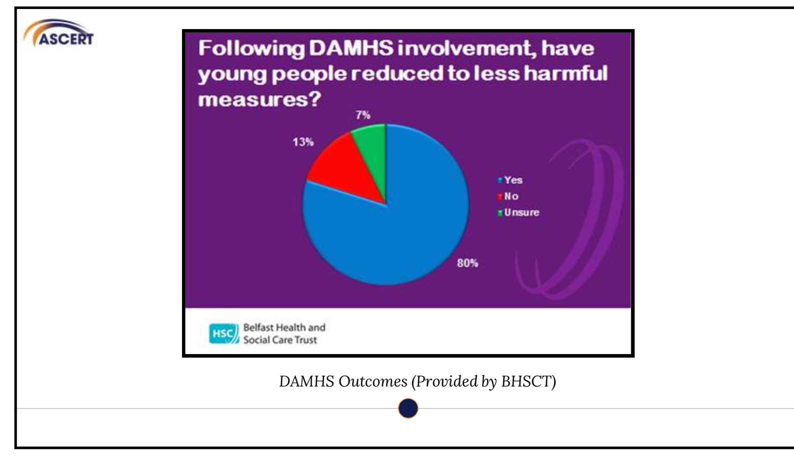


Thinking About Our Approaches

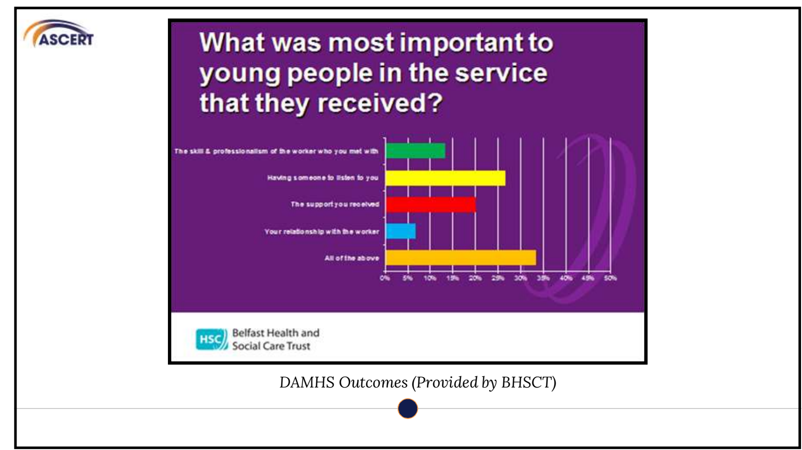
In groups, look at the case scenario; imagining the young person there with you, each group member should act as a representative from the organisations mentioned in the text. Role play what you think your role is in this situation.



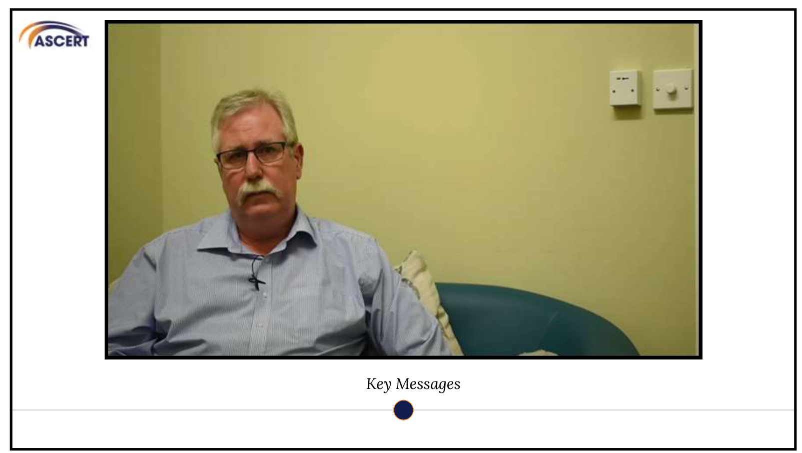
Integrating Trauma-Informed Practice



DAMHS Outcomes (Provided by BHSCT)



DAMHS Outcomes (Provided by BHSCT)



Key Messages

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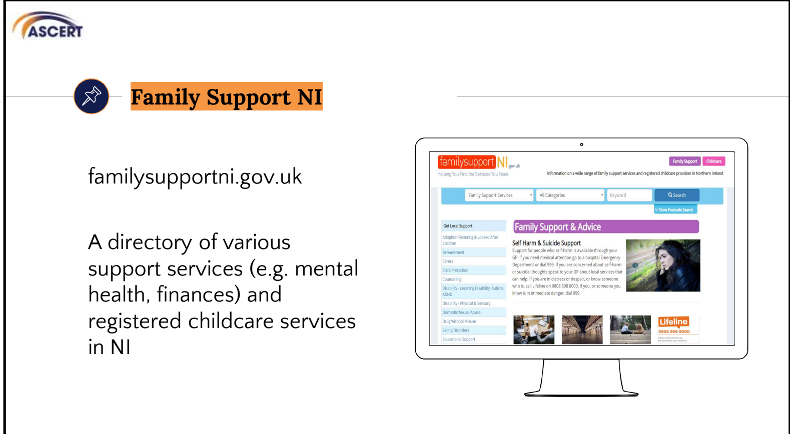

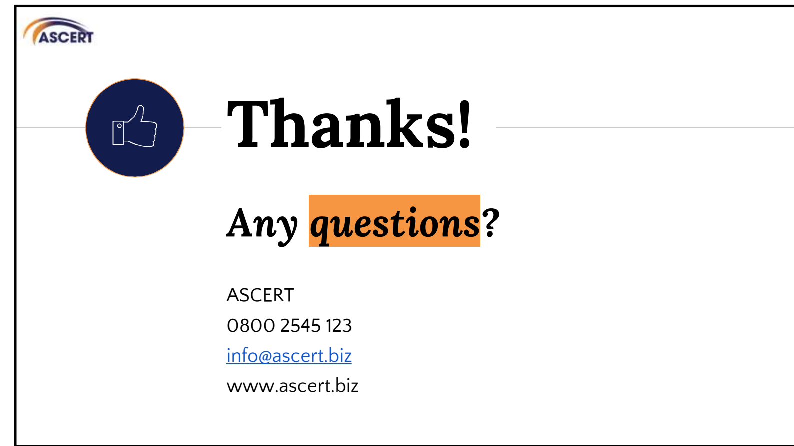
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Thanks!
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