Faculty of Child & Adolescent Psychiatry Executive Committee Newsletter

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Vice Chair

Jon Goldin

Finance Officer

Alka Ahuja

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Rory Conn
Nicole Fung
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Ann Collins
Andrea Danese
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Mark Lovell
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Birgit Westphal
David Williams
Richard Wilson

In this issue

Louise Theodosiou

Welcome to this winter edition of the newsletter, I would like to take this chance to congratulate Elaine Lockhart on her new role as Chair and Alka Ahuja as Vice-Chair. I would also like to thank Bernadka and Jon for all the excellent work they have done in their roles. The ongoing challenges of the pandemic and the impact on the health and wellbeing of children and families has demanded strong leadership and I am confident that Elaine and Alka will continue the excellent work of the Executive.

This newsletter reflects some of the complexity of our year of lockdown with some pieces from 2020 and some from 2021. Apologies for the lengthy chronological span covered, I am confident that later editions in 2021 will be more timely. That being said, the pieces are all excellent and thought provoking.

Finally, I would like to thank Stella for the amazing support that she provided to our Faculty, we wish her all the best in her retirement.

Dr Louise Theodosiou
Editor
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Bernadka Dubicka

Newsletter May 2021

Bernadka Dubicka

A lot has happened since the publication of our last newsletter almost a year ago – a year that has been defined by the pandemic. Although here in the UK we are finally seeing light at the end of the tunnel, at least for now, tragically this is not the case in many other parts of the world, and I am aware that many of you will have friends and family who may be affected. As we try and get back to our new normal, we are constantly reminded of how fragile this may be.

This is also my final contribution to the newsletter as Chair of the Faculty, and I will try and summarise some of the key work of the executive during this momentous year.

One of our key achievements this year was to emphasise to the college that children and young people needed to be prioritised within the College Strategy, particularly as they have been disproportionately affected by the pandemic. My colleague Professor Tamsin Ford, who is leading on the NHSX prevalence study, reported that between 2017 and 2020 child and adolescent mental health disorders increased from 1 in 9 to 1 in 6, and, according to NHS Benchmarking, demand has never been higher. We have been regularly highlighting the impact of COVID-19 in the media, with numerous appearances. I was also invited to give evidence to the Education Select Committee earlier this year to discuss the CAMH crisis and am due to give evidence to the Health and Social Care Select committee. We will continue our work with the college to give this issue as much traction as possible with government.

As well as keeping the pressure on government to give more funding to CAMH, we are also pushing for a 10-year workforce plan in order to implement the NHS 10-year plan, which has been wholly lacking. Similarly, there is no detail in the plan about how we can meet the 'need' of all CYP ages 0-25, when we are nowhere near able to treat existing mental health disorder in the majority of school children. The schools mental health support teams are being rolled out in England, which is a start, but many gaps still exist in service provision.

Recruitment and retention remains our top priority and while psychiatry has recently increased numbers by 7.5%, Child & Adolescent Psychiatry has only increased by 0.9% (and numbers of consultants have fallen since the promise by Five Year Forward to deliver 100 more), whereas in Medicine they have increased by 29%. Together with Holan Liang, our workforce lead, we recently attended the College Workforce Committee to highlight the shortfall in CAPs. I am pleased to say that Kate Lovett, outgoing Dean, and new college workforce lead, has committed to using CAP as an exemplar for working on an urgent recruitment and retention plan. We also had a productive meeting recently with other colleges led by our President regarding the urgent need to address the huge pressures on emergency and paediatric services regarding mental health crises in children and young people. There is a significant momentum around this work, particularly in light of COVID-19, and we aim to involve the medical academies to give it the traction that it needs.

The pandemic has brought to the fore intense debates about inequalities and the college has signed up to The Inequalities in Health Alliance, a coalition based at the Royal College of Physicians, which has a 'child health in all policies' ask for government. During our college-wide strategy day, it was agreed that one of our campaigns will be on inequalities and I have called for child impact assessments on our college outputs, a young person representative on council, and that prevention and early intervention should be a key priority for the college. Our new Registrar, Trudi Seneviratne, who was previously chair of the peri-natal faculty, is keen to support the development of an early year's strategy as one of her priorities and we will be working closely with her to achieve this.

Broadening participation remains one of our key strategies, and we appointed two excellent young people to our executive, Nathan Randles and Rhiannon Hawkins, who have been doing a fantastic job, particularly regarding our greener CAMHS work. I hope that we will also be able to have the voice of a young person on the college council, so that young people can be involved at the college strategic level too. Toni Wakefield has been re-appointed as our carer representative, in light of her extensive experience of participation, and in particular, her experience in training CAMHS staff in collaborative working.

Another area where we continue to work to make an impact is the government online harms white paper. We have all made use of enhanced technology during this pandemic; however, we also want to ensure that CYP have the same rights to safety in their online world as they do in the offline world. Building on our paper from last year, we have consulted to OFCOM, the appointed regulator, as well as to DCMS, and I gave oral evidence to the House of Lords Technology Select Committee on this topic, which received significant media coverage, so we have had an opportunity to influence in this important area.

On a related note, Alka Ahuja, digital CAMHS lead for the Welsh government, has led the way on the use of remote working during this pandemic and was recognised for her work in this year's Honours list. Thank you also to all of you who responded to our survey on remote working, and to Anupam Bhardwaj, Alka and her team for working on this. We hope to publish the findings soon, but, not unexpectedly, you gave us a mixed picture regarding the uses of remote working, and finding optimal, blended approaches will be the way forward. COVID-19 has given us an opportunity to fast-forward technology and find new and sometimes improved ways of delivering services to families. However, 'Zoom fatigue' (as well as pressure sores) has rapidly become a new work-related stress, and it will be important to find the right balance between remote and face-to-face working for us and our patients in the future.

For those of you who attended our first remote college conference, I hope that you enjoyed the experience, albeit without our usual coffee breaks and social activities. Our Faculty was the first to have a full online annual conference, and thanks to Catherine Ayres and her conference team, as well as our new academic secretary, Andrea Danese, and his deputy Marinos Kyriakopoulos, for making this happen. It's not the same as in person, but it did mean that many of you were able to join, who may not have been able to make it to London. We chose the topics that seemed to be of most relevance to our CYP during this crisis, namely inequalities, COVID, and climate change with high profile keynote speakers (Michael Marmot and Tony Costello).

There are many issues impacting on the mental health of young people during the pandemic, but their health and future will be entirely contingent on ensuring that our planet has a future too. The winter conference therefore continued with the theme of the eco crisis and its relevance to child and adolescent psychiatry. It looked at activism, the impact of the climate crisis on child and adolescent mental health and interventions that could be done within a greener framework. Our youth advocates helped facilitate the day and we had an inspirational keynote from Dr Lise Van Susterans, who gave evidence on the impact on mental health during a court case brought by young people against the US government.

In line with the NHS Net-Zero target, we have worked with the college on a position statement on the eco-crisis, which was recently published, together with a declaration of a climate emergency. We plan to build on our work with our greener CAMHS coalition and have applied to host an event at the 26th UN Climate Change Conference of the Parties (COP26). Congratulations also to our green scholar Kathryn Speedy for her appointment and work on our eco-crisis survey. Please do look at our conference resource page: https://www.rcpsych.ac.uk/improving-care/working-sustainably/sustainability-resources

Another area which I know causes significant concern to members are gender identity services and the college position on this. We have been invited to participate in the NHSE commissioned review by Hilary Cass, along with the medical academies. The college position is that this is not primarily a psychiatric condition, and therefore other colleges also need to be involved in this review; however, these CYP often have comorbid mental health disorders and therefore it is important that we also contribute to assessments and treatment of relevant conditions.

Other important work includes the soon to be published review of inpatient services by Guy Northover, GIRFT lead; our joint statement on PANS/PANDAS with the BPNA led by Ashley Liew (https://bpna.org.uk/?page=pans-pandas); the college response to the Mental Health Act Review White Paper consultation; and our 0-25 paper, which is in press.

Finally, many congratulations to our new elected officers: Elaine Lockhart, Chair, Alka Ahuja, Vice Chair, and Guy Northover, Finance Officer. They have all been excellent colleagues and I know will do a brilliant job representing you. On that note, I will say goodbye and thank all my wonderful colleagues on the exec and at the college who have been a pleasure to work with, including Jon Goldin, Vice-Chair and Stella Galea, our recently retired exec manager. Although these past 4 years have been demanding, I hope that together we have continued to make sure that CYPMH continues to have the high priority that it deserves. Although I am stepping down from my role as chair, I hope that in my new role as Editor-in-Chief of the Journal of Child and Adolescent Mental Health I can continue to promote high quality clinical care and provide a forum for important issues both in the journal and through the many free and low cost ACAMH events: if you aren't already a member, do please join – hope to see you there.

Dr Bernadka Dubicka
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Report from Scotland

Elaine Lockhart

Greetings from Scotland where we are living again with significant restrictions on our daily lives due to COVID-19, which include not being able to visit other houses. Last night we had our first frost, and it is going to be harder to meet up with friends and family over the autumn and winter months. At work we are needing to dial back from the remobilisation plans and return to more working from home and bringing up to clinic only those children and young people who must be seen face to face. It may be pathognomonic of middle age to regard the closure of pubs and restaurants at 10 pm as perfectly acceptable, but already there are dark mutterings of Christmas being cancelled!

CAMHS activity around the country continues at previous levels, with much work being done remotely and high numbers of children and young people being referred and waiting for specialist mental health input. Locally we have seen some extreme presentations of children who are presenting for the first time to CAMHS whose functioning and/or that of their families have been badly affected by the lockdown and/or the return to school. As with colleagues around the UK, the next few months will be challenging for all of us to continue to provide a high-quality service while contending with a second wave of COVID-19.

Happily, there have been some high points for our Faculty here over the past while. Last week I was supported by College Officers in interviewing 4 candidates for the 2 posts of Patient Representatives for our Executive. It was really difficult to choose, but we can now look forward to working with 2 outstanding young people who have had mixed experiences of CAMHS and are bright, articulate, and passionate about wanting to help us improve mental health services for children and young people.

Our colleagues working in LDCAMHS submitted extensive feedback about the needs of vulnerable children during the COVID-19 pandemic and its impact to a Parliamentary committee. Building on this, the RCPsychiS hosted a webinar about this topic in September with speakers from Young Scot, Educational Psychology, the Royal College of Paediatrics and Child Health, a parents advocacy group and LDCAMHS a link here to the webinar recording

Although our work with the Scottish Government has been delayed, we hope that the work on developing a national specification for specialist CAMHS and for neurodevelopmental disorders will continue and can be used in local discussions about how to provide these services in a sustainable way. Colleagues have been working with the College regarding the review of the Mental Health and Adult with Incapacity legislation.

We are looking forward to our AGM and annual academic meeting on the 25th November which will be a half day conference, with presentations on PANDAS/PANSS and the results of the NHS Digital epidemiology study. If you are interested in joining this, please contact Susan Richardson at the RCPsychiS. I will be coming to the end of my term of office as Chair and am hugely grateful to our wonderful colleagues at the RCPsychiS, on the CAPFEC and those working in CAMHS in Scotland for making this such an enjoyable and rewarding 4 years.

Dr Elaine Lockhart
Chair of the Faculty in Scotland
c/o Catherine.Langley@rcpsych.ac.uk

Report from Northern Ireland

Mark Rodgers

In this, my first submission to the Newsletter as Chair of Northern Ireland CAP Faculty I would like to start by thanking Richard for his hard work during his tenure and wish him every good success in his new role as Chair of RCPsych NI and Vice President of RCPsych. I have served as Vice-Chair locally for a number of years during Richard's tenure; so, I know well the dedication with which he exercised that role. Richard's unassuming elegance and unique way of connecting with people has benefitted the NI Faculty greatly. Whilst I probably cannot match the usual poetic ethos of his former Faculty updates, I will reiterate a quote from Da Vinci that Richard once said to me: *'Simplicity is the ultimate sophistication'.* It is my hope that my Newsletter contributions moving forward epitomise that statement.

This year the College in NI bids a fond farewell to Clifton House which has been our home here for many years. We embark on a new journey in the aptly named *Innovation Factory* – a workspace that will hopefully help foster *innovation* and creativity when the College staff here return from remote working practices. Certainly, taking up role as Chair has been a little bit different with the changes that COVID-19 has brought to professional ways of working as well as most other aspects of our lives. That said, the pandemic whilst changing the way we work, has in no way dampened the work ethic in NI.

Indeed, the College and Faculty here have been at the forefront of informing Department of Health policy around matters arising for mental health related to the pandemic. The latter potentially represents one of the biggest challenges we as a Faculty, and as a specialty, face in the *reset* agenda. To this end I have represented the Faculty on *The Children and Young People's Strategic Partnership* to produce a scoping paper for the Department entitled '*Managing the impact of COVID-19 on the Mental Health and Emotional Wellbeing needs of Children and Young people in Northern Ireland'.* Until recently Richard represented the College on the Project Board of NI's first *'Prevalence study* *into the mental health of children and parents in Northern Ireland'*. The overarching aim of this study is to provide the first ever reliable estimates of the prevalence of mental health disorders in children and young people in NI based on ICD-10 diagnostic criteria. The results of this will be launched in October 2020.

The local College COVID-19 Reference Group has contributed to a '*Mental health action plan'* which will inform service provision in a post COVID-19 landscape. Additionally, in July 2020 colleagues presented the initial findings of a study concerning the *'Integration of remote ways of working into psychiatry'* which sought to use the COVID-19 scenario as an opportunity to review the evidence base for tele-psychiatry and posit what opportunities there are to develop and sustain this way of working in NI where appropriate.

In a similar ethos colleagues at The University of Ulster, produced a paper that surveyed over 4000 households across NI following school closures here since March 2020 – some key messages arising from that endeavour included potential for a '*fresh consideration of the shape of the education system* in NI*; effective school-parent partnerships; the skills base of teachers; digital and communication networks development…'*

In the Spring Newsletter Richard highlighted that the *'balance between evidence, panic and planning is a constant challenge'* in the COVID-19 scenario. Given the steadfast commitment I have witnessed from colleagues to their patients in the clinical domain, as well as the excellent work the Faculty in NI has produced during this challenging time; reassures me that Faculty members have faced these challenges head on with professionalism and a resolve that keeps our patients' welfare at the forefront.

Dr Mark Rodgers
Chair of Faculty in Northern Ireland
c/o Catherine.Langley@rcpsych.ac.uk

Report from Wales

Kristy Fenton

The Welsh C&A Faculty has been heavily involved with feeding into to the Welsh Government's policy and guidance in response to COVID-19 and the recovery and creating resources to support children and young people.

Since the start of COVID-19 we've submitted written evidence to the Children, Young People and Education Committee at the Senedd and attended an oral evidence session to respond to the committee's questions directly, pressing the importance of supporting children's and teacher's mental health during the return to school.

Dr Rhys Bevan Jones, Prof. Anita Thapar and Prof. Frances Rice at Cardiff University have produced a plethora of resources including "Moodhwb: A digital Intervention for adolescent depression" to be tested in schools as part of the COVID-19 recovery. Members of that team, alongside others, have also created animated digital resources to help people understand ADHD in schools. Just before lockdown, our own Dr Jacinta Tan went into a school in Newport to deliver her "Celebrate Every Body" workshop on body image. Projects like these will undoubtedly help to support young people's mental health through the recovery.

We're continuing to feed into the Welsh Governments work on the interface between health and schools by responding to their consultation on the Whole School Approach to Mental Health and Wellbeing, which sets out how education and health sectors should interact to provide mental health support.

Throughout COVID-19, A major part of the Welsh Government's approach to managing the disease in healthcare settings has been through the delivery of video conferencing / telehealth. One of the Faculty's members, Prof. Alka Ahuja, who also sits on the RCPsych Wales Exec as Public Engagement Lead has been the Clinical Lead for TEC Cymru, responsible for designing and delivering guidance for telepsychiatry, based on her own experiences with the CWTCH (Connecting with Telehealth to Children in Hospital Settings) Pilot, in the Specialist Neurodevelopmental Services at Aneurin Bevan University Health Board.

We'll soon be responding to a further consultation on the Welsh Government's Code of Practice on the Provision of Autism Services, outlining how we would like to see services delivered for all people with a neurodevelopmental disorder.

Dr Kristy Fenton
Chair, Faculty of Child & Adolescent of Psychiatry, RCPsych in Wales
c/o Oliver.John@rcpsych.ac.uk

Coronerve Surveillance Survey

RCPsych

Dear Colleagues

Please support The Surveillance Study of COVID-19-associated Neurological and Psychiatric Conditions. The RCPsych is one of several organisations supporting a programme run by Benedict Michael (NIHR Health Protection Research Unit for Emerging and Zoonotic Infection, University of Liverpool). The programme seeks cases of neurological and psychiatric syndromes associated with suspected or confirmed COVID-19 infection and/or vaccination.

Please report cases via this RCPsych web portal – it is very brief and will take < 5 minutes.

No patient identifiable details will be needed. The Health Research Authority have reviewed and approved the collection of these data for health surveillance.

The data being collected is a very brief survey with four questions: the patient's SARS-CoV2 status (COVID-19 virus), their psychiatric status and their neurological status if known to you.

Please keep your own record. Before you click 'Submit', please print the completed page, and keep it alongside a note of the patient's medical record number, so that you can provide more details when Dr Michael's team contacts you, as we will seek more details on these cases in the fullness of time. We will remind members about this form via our weekly COVID-19 email, until there is no need for continued surveillance.

Thank you for your support.

Best wishes,

- Dr Adrian James (President)
- Dr Mike Dilley (Neuropsychiatry Faculty Chair).
- Benedict Michael (NIHR Health Protection Research Unit for Emerging and Zoonotic Infection

On behalf of:

- NIHR Health Protection Research Unit for Emerging and Zoonotic Infection Programme Study Management Group: Rhys Thomas, Rachael Kneen, Ian Galea, and Sarah Pett.
- RCPsych Group: Alan Carson, Tony David, Mike Dilley, Tim Nicholson, Tom Pollak, Valerie Voon.

c/o Catherine.Langley@rcpsych.ac.uk

Call for the National rollout of 'early support hubs'

Collaboration of wellbeing groups

Youth Access, The Children's Society, Mind, Young Minds and the wider Children and Young People's Mental Health Coalition launch their joint #FundTheHubs campaign on Tuesday 8 June 2021, calling for the national rollout of 'early support hubs'.

Early support hubs provide easy to access, local support for young people aged up to 25, without the need for a referral or an appointment. They offer psychological therapies as well as advice and guidance on other issues impacting young people's lives, such as housing and employment.

These hubs are based on existing services models from the UK and internationally, such as the Youth Information Advice and Counselling Services (YIACS) which make up a large portion of Youth Access' membership.

Together, we are calling for proper funding in these services - at least £150million - so that every single young person in England can access a 'hub'. Investment in early support hubs will ensure that young people can access the mental health support that they need, reduce pressures on NHS services and improve young people's prospects across the whole of the life course.

To find out more and support the campaign, go to https://www.youthaccess.org.uk/our-work/fundthehubs

c/o Catherine.Langley@rcpsych.ac.uk

RCPsych member survey

First ever RCPsych member survey

The College is launching its first ever comprehensive membership survey – which will be open to all members between **19th May and 13th June 2021**.

Look out for emails from Research by Design.

containing a link to complete the survey.

The RCPsych is your College, please help shape its future.
c/o Catherine.Langley@rcpsych.ac.uk

Infant Mental Health

Dr Clare Lamb

This week is Infant Mental Health Awareness week, and the theme is:

"Including infants in children and young people's mental health"

To coincide with this, The Parent-infant Foundation have released their survey report on provision for infants and their parents/carers in CAMHS

The RCPsych is thanked in the methodology section of the report. The respondents to the survey included 42 psychiatrists.

Paediatric Liaison Update

Dr Virginia Davies

PLN update 9 June 2021-06-09

Work with NHSE
Pratibha is obviously our key person in NHSE and is a member of the PLN mail base, so that is great. In addition, Bernadka, Elaine, Birgit and I have all been at various meetings and workstreams in which NHSE have been involved.

NCEPOD/AOMRC Stakeholder meeting on 18/3/21. This meeting followed the NCEPOD report on the quality of care provided to young people with a mental health conditions in September 2019; they were keen to see it make an impact rather than languish in the long grass. As such, all the Colleges were invited to the meeting and will continue to work together on lobbying for better provision with the AoMRC supporting this.

Meeting of RCPsych, RCPCH and RCEM convened by Adrian James on 5/5/21 in order to share thoughts and feedback to Ruth May, chief nurse at NHSE, who had asked for ideas about how to respond to the increasing numbers of CYP in EDs and on paeds wards with MH issues.

Most recently, the Mental Health in CYP Physical Health Services group which is hosted by the RCPCH with representation from RCPsych, RCN, ACP, NHSE, HEE, RCGP and RCP had its most recent meeting on 27/5/21. The group has produced a position statement relating to the need for adequate MH provision within physical healthcare settings that is in the process of being endorsed by all Colleges. At this meeting, the group were briefed about a new NHSE programme of work centred around meeting the needs of CYP with mental health presentations in paediatric settings (given the previously noted sharp rise in numbers over 2020/21). The programme will include setting up a website with links to training and co-production of guidance and will link to another recent NHSE workstream, namely a task and finish group aimed at addressing the workforce demands of increasing numbers of CYP with MH issues on paediatric wards.

Links within RCPsych
Liaison Faculty: Birgit Westphal, ex-chair of PLN now an exec member of LP, and I am co-opted member.

PLAN: Birgit is on the accreditation group for PLAN and I am on the advisory group, last meeting 24/5/21 (PLAN sets all the liaison standards by which acute trusts' mental health provision is assessed. Mainly this centres around the emergency offer)

Links with RCPCH:
As above, as well as Rory Conn being our faculty link – see his separate report re the Emergency Standards Committee and other workstreams.

PLN meetings:
Summer meeting 25 June being hosted by Elaine and colleagues will cover the areas of how to manage the care of the hugely increased numbers of CYP with restricted eating on paeds wards – by training up physical health staff – and an update from Tamsin Ford about the changing epidemiology and rates of CMH conditions in the most recent studies.

Winter meeting last January was very successful and hosted by GOSH. Had very helpful updates from our Danish colleague Charlotte Rask on group interventions for MUS and a fascinating couple of presentations about the work with children in PICUs from our Dutch colleagues, Jacqueline Strik and Nathalie Janssen

Next winter's meeting, again hosted by GOSH in January 2022, has planned talks from Sharon Taylor and Matthew Hodes on the evaluation of brief CBT interventions to address maternal anxiety in children with food allergy and Gordon Bates talking about his groups review paper on pervasive refusal syndrome.

Dr Virginia Davies
Paediatric Liaison Network Chair
c/o Catherine.Langley@rcpsych.ac.uk

CAPSS Autumn Newsletter

CAPSS Executive Committee

CAPSS Autumn Newsletter

Despite all the turmoil of the last few months the CAPSS committee has continued to meet virtually. We have some updates regarding GDPR for which we need your support and some changes to our reporting system. Our website has been revamped (see link below) and we continue to see good impact from our studies.

Contact details of consultants

Having up-to-date contact details for consultants who take part in the active surveillance is essential to ensuring that researchers can contact the consultants who have notified CAPSS that they have seen a case of one of the rare disorders. Please ensure that we have the correct work contact details for you by contacting us on CAPSS@rcpsych.ac.uk.

New E-Card launch We will soon be launching a new and simplified e-card. Examples of how this will look are below.

Landing page of new E-Card

CAPSS E-Card

There are TWO studies running on CAPSS; Early Onset Depression and Sydenham's Chorea. The research protocol cards and reporting instructions are available by clicking here. You can also find the public information sheet which is free to display on hospital parent information boards.

Have you seen any cases of children or adolescents with Early Onset Depression or Sydenham's Chorea in:

○ April 2020
○ May 2020
● June 2020
○ July 2020
○ August 2020
○ September 2020
○ October 2020
○ November 2020
○ December 2020

Continue to the next page to enter data for the selected month

Reporting page of new E-Card

Have you seen any cases of children and adolescents with Early Onset Depression (EOD) in June 2020

○ Nothing to Report ● Case(s) Seen

Please specify in the box below the number of cases seen

1

Did you see any cases of children and adolescents with Sydenham's chorea (SC) in June 2020?

● Nothing to Report ○ Case(s) Seen

If you have reported a case please be sure to record the patient's details as a recall aid for when you are contacted by the research team.

Please use the space below to inform us if you have retired OR no longer have clinical work OR have changed your work/ email address

If you think you may have missed a month of reporting please contact the CAPSS Team

Thank you for completing the CAPSS E-Card.

Kind regards,

CAPSS Team

Study Updates

We are continuing to collect data for the Sydenham's Chorea study which is a joint study with BPSU.

Website updated.

We have updated our website. Please do take a look as it does give a good overview of our current and previous work. We hope you will find the information you need easily.

https://www.rcpsych.ac.uk/improving-care/ccqi/research-and-evaluation/current-research/capss

Impact

CATCh-uS Mapping study

The mapping study aimed to create a list of existing National Health Service (NHS) provision in the UK for young people with Attention Deficit Hyperactivity Disorder (ADHD) aged 18 and above. This is intended to inform future service provision and improve transition from children's to adult's services. http://medicine.exeter.ac.uk/catchus/mapping/

Vice Chair of CAPSS

We are seeking expressions of interest from consultants in child and adolescent psychiatry for the post of Vice Chair of CAPSS. This is an exciting opportunity to contribute to the work of CAPSS. Please contact Dr Adi Sharma (Chair, CAPSS) on aditya.sharma@ncl.ac.uk

Congratulations to Prof Tamsin Ford CBE

We want to give warm congratulations to Professor Tamsin Ford who was awarded CBE for her services to psychiatry in the 2019 Queen's birthday honours list. Her work has been cited in recent health and education policy documents and is regularly cited in government. She has chaired the CAPSS committee for 10 years and continues to support the committee into the next decade of work.

Consultants returning e-cards

The responses of CAMHS consultants as to whether you have seen any cases of the rare disorders advertised is fundamental to the success of the surveillance system. **REMEMBER** that a "No I have not seen a case" response is as important as a positive report, so that we can establish a response rate. If you do not fill in the survey, we do not know if you did not see a case or did not receive the e-card. Please email the CAPSS office if you would like to fill in past months of the Sydenham Chorea's e-card.

CAPSS Executive Committee

c/o Catherine.Langley@rcpsych.ac.uk

Child and Adolescent Spirituality Conference

Spirituality and Psychiatry SIG

My colleagues Dr Lucy Grimwade, Dr Gloria Dura-Villa and I are three Consultant Child Psychiatrist members of the Spirituality and Psychiatry Special Interest Group. We are in the preparation phase of a rather comprehensive conference on Child and Adolescent Spirituality and its relevance to mental health and CAMHS in general.

The identified date of the conference is 10th December 2021. Sounds like a long way away, however, we are very keen to publicise/advertise the conference to the right audience.

We will be grateful if you are able to accommodate this request.

Dr Lucy Grimwade is leading the conference organization and all three of us will be happy to answer any queries.

Dr Omur Miles – Consultant Child and Adolescent Psychiatrist, Gloucestershire
c/o Catherine.Langley@rcpsych.ac.uk

Trainees' Report

Omolade Abuah and Kiran Panesar

We would like to welcome our new Trainees who have just started the Scheme, both Run-through Trainees and the SPRs who have joined the higher training. We are both trainee reps and happy to help should you need any clarifications or support. I stand in for the run-through trainees while Kiran represents the higher training programme. Our tenure as reps also comes to an end after the conference and we have sent an email round to inform you of this. For those interested, the email also includes the role description, and it is a great opportunity for you.

We are very excited about the upcoming 19th Annual Trainee conference as we have just confirmed the line-up of speakers. We have considered feedback from last year's conference in helping us choose speakers and topics. The speakers range from our different sub-specialties in Child and Adolescent Psychiatry and covers those ILOs we all find difficult to get ticked off. This would be the very first virtual trainee conference for the CAP Faculty, and we are confident that though we are not meeting in person, the topics chosen would have us all interacting and asking questions in the chat boxes with piqued interest. The call for posters is out and we hope to get a lot more interest this year with this being a virtual conference and being easier for trainees to access. Please do not hesitate to send your abstracts in the advised outline and format by the deadline advertised. We are looking forward to reading about the exciting work you have all been doing!!

We have also had the annual medical student essay competition with Ella Sykes emerging as winner. There were good articles written by medical students from all over the country which highlighted the impact of child poverty on the mental health of children and young people. She has earned a free place at the Trainee's conference and her article, and a few others would also be featured on the conference page for others to read. So please look out for this.

It's been quite a challenging year for everyone, and we know it would have been for Trainees especially with concerns around impact of training and ARCPs. The first batch of trainees to have had ARCPs with special COVID-19 amendments have taken place and we have had good feedback that this has allayed the anxiety for quite a number of trainees regarding progression.

We look forward to meeting you all at the conference virtually.

Kiran Panesar and Omolade Abuah

c/o Catherine.Langley@rcpsych.ac.uk

Harrington Essay Prize joint winner: Sure Start 2.0: What would I do to improve the wellbeing of children and young people.

Anna Eaton

INTRODUCTION

> *"Anyone who has struggled with poverty knows how extremely expensive it is to be poor" - James Baldwin*

One third of children in the UK are victim to poverty – one of the most evidenced and universal threats to wellbeing[i]. Living in financial hardship has significant detrimental consequences for family functioning, parental[ii] and child mental health[iii], cognitive development, educational attainment, and physical health. As such, the trajectory is often an enduring 'cycle of poverty'. Well executed government investment during 'early years' has significant potential to improve the wellbeing of children living in poverty.

EARLY COSTS

Socioeconomic status shapes maternal health through mediators such as nutrition, stress, anxiety, smoking, drug, and alcohol use. Prenatal environments influenced by these may induce permanent structural and metabolic changes during foetal brain development. This mechanism is implicated in developmental disorders (e.g., Autism and ADHD) as well as lifelong mental health vulnerabilities[iv,v]. Mothers from disadvantaged backgrounds are more likely to have babies with low birth weight[vi], which correlates with poor educational and physical health outcomes. Poverty is associated with lower rates of breastfeeding and higher rates of post-natal depression[5].

A critical period of development occurs in the first three years of life; children learn through exploration and play facilitated by their parents. They imitate the actions and language of others with increasing sophistication. Babies engage in a rhythmic interactive 'reciprocity' with their caregivers. Inevitable but temporary asynchrony in this to-and-fro helps the child tolerate a 'rupture' in the dynamic and anticipate 'repair' in relationships[vii]. Parental perception and interpretation of their infant's behaviour is fed back to the child by responding to the imagined mental state[viii,ix]. Intuitive responses that are 'good enough'[x] embed epistemic trust as a channel of social learning and allow the child to develop a reflective capacity[xi,xii,xiii]. This promotes the ability to understand one's own mental state and that of others. If the parent is not interactive, depressed or otherwise emotionally unavailable ('still faced'[xiv]), these processes can be disturbed. This leads to a reduction in the number of developing neuronal connections, thus limiting the architecture for self-regulation, problem solving, communication and relationship building[10].

Children who fall behind in their development early are significantly less likely to catch up. Even disadvantaged children with high cognitive scores at 22 months of age are likely to perform worse when subsequently tested, compared to their peers from wealthier families[xv]. Speech and language discrepancies between those from deprived and more affluent backgrounds are evident by the age of three[xvi]. Unsurprisingly then, impoverished children enter school with fewer interpersonal or social-emotional skills and a year behind their expected development. At 16 years old, the differences are widened; just 33% of pupils qualifying for free school meals achieve five 'good GCSEs', compared to an average of over 60% for those not eligible[xvii]. The very worst off are nearly two years behind by the end of GCSEs[xviii].

The primary influence of emotional health and wellbeing in childhood is the quality of family relationships[6]. Parents in poverty face a myriad of additional challenges that may impact their ability to provide an enriching and stimulating environment or be reliably available, supportive, and comforting. These parents are more likely to be affected by mental and physical ill health or disability, low educational attainment, unemployment, social isolation, domestic violence, substance misuse and poor-quality housing in high crime areas[xix]. Research highlights that disadvantaged parents have more inconsistent and ineffective behavioural management strategies[xx], harsher authoritarian parenting styles and propensity to negative emotional appraisals of their children[xxi]. Parents suffering from financial hardship tend to be less nurturing, attentive, and emotionally available, which is largely related to depression[19].

When the basic physiological and safety needs of the family are not met[xxii], the ability to foster secure attachment between parent and child is impaired[xxiii], particularly if parents lack secure attachments themselves[xxiv]. The security of healthy attachment allows children to develop a positive representation of self and others, manage threats, stressors, and emotional distress - equipping them with psychological resilience[xxv]. Without this, children are left in a state of uncertainty with regards to threat, safety, and comfort. As a result, they struggle to self-regulate their arousal system and become dependent on adaptive strategies to maintain caring relationships[25]. Insecure attachment gives rise to a negative sense of self and others; hence less time is spent in positive affectivity[25]. These early patterns are associated with a lifelong predisposition to depression, anxiety-related mental illness, and personality disorder[13].

PAYING THE PRICE

Adversity and trauma further compromise the developing child’s ability to think, learn and interact. As scaffolding for a child’s understanding of reality is framed through their parents, they can vicariously experience parental and transgenerational trauma. An impoverished upbringing is more likely to feature adverse childhood experiences (‘ACEs’) which have been associated with up to 45% of childhood mental health disorders[xxvi] and an increased risk of suicide[xxvii,xxviii]. Research has focused on outcomes of those meeting a threshold of four or more ‘ACEs’, applicable to 8-14% of the British population[xxix,xxx]. This demonstrated an increased likelihood of behavioural or learning difficulties[xxxi], unintended pregnancy, violence, health harming behaviours, cardiovascular disease, diabetes, cancer, chronic lung disease and premature death[xxxii]. These risks can be mitigated through a stable, positive relationship with one trusted adult[xxxiii,xxxiv]. This highlights the importance of parental support in developing sensitive, responsive parent-child relationships that is accessible to disadvantaged families.

Children in poverty are 3 to 4.5 times more likely to experience severe mental health disorders and behavioural problems (e.g. conduct disorder and ADHD[xxxv]) when compared to more affluent peers[xxxvi,xxxvii,xxxviii]. It has been proposed that stress in critical periods can lead to expression of genetic vulnerabilities to schizophrenia and schizophreniform illness[xxxix], and indeed children in poverty are nine times more likely to experience psychosis[16].

There are 4.1 million children living below the poverty line. This is projected to rise to 5.2 million by 2022[xl]. Half of these children are in ‘persistent poverty’, whereby their circumstances are unchanged for more than three years. This is a risk factor for ‘internalising’ manifestations of psychological distress and lower subjective well-being as children and in adulthood[34,xli]. Increasing deprivation is not thought to be directly responsible for the climbing prevalence of emotional disorders, however a socioeconomic gradient is now present[xlii].

Research on the relationship between low social class and increased rates of borderline and schizotypal personality disorders suggest that there is a failure to 'grow out of' maladaptive, dysregulated behaviour and a delay in emotional development. In the case of borderline personality disorder this is over five years per standard deviation from the mean family income[xliii].

'Current poverty' is commonly linked to 'externalising' behavioural difficulties[18] which has been demonstrated in children as young as three[xliv]. 70% of children with conduct disorder come from the most financially deprived backgrounds[8]. It is well established that poverty acts as a predictor for childhood delinquency[xlv] and antisocial personality disorder[xlvi].

EARLY YEARS INTERVENTION

"Overcoming poverty is not a task of charity, it is an act of justice" - Nelson Mandela

There is both a moral and economic imperative for the government to address child poverty, with the consequences costing over an estimated £29 billion annually[xlvii]. Changes to the tax and benefit systems offer a quick remedy to increase household income. Yet with the fragility of the economic climate and many opposing political fiscal ideologies, how can this complex problem be approached meaningfully?

53% of children in poverty in the UK are younger than five[xlviii]. Sure Start centres were introduced in 1999 as multi-agency community hubs with the aim of improving life chances of these young children. They were inspired by the success of 'Head Start' in America, which was established in 1965, achieving positive outcomes of improved childhood cognitive development, social competence and attention[xlix]. At its peak there were 3,600 Sure Start centres around the UK, concentrated in disadvantaged areas. They forged a positive alliance with a hard-to-reach group, offering an opportunity to improve their quality of life. Free blended childcare with early education was offered with the aim of addressing the attainment gap through 'catch-up' learning. Close links with the Jobcentre Plus empowered and encouraged parents into work or training. Sure Start incorporated child and family health services including antenatal and postnatal resources (advice on breastfeeding, nutrition, smoking cessation and parenting classes) as well as access to specialist services through outreach provision[l]. Multidisciplinary approaches sought to optimise attachment and improve the quality of parental interactions through psychoeducation, 'stay and play' groups, antenatal and postnatal support groups and infant massage sessions for depressed mothers. More targeted interventions included video recorded guidance and parent-infant psychotherapy including 'Watch, Wait and Wonder' groups. The 'Solihull Approach' relational model (focusing on the emotional containment of parents and child by proxy) was pioneered through Sure Start and now has a substantial evidence base.

Sure Start was initially managed by central government with ringfenced funding. Each centre was shaped to serve its local community by input from a panel of parents and representatives from the organisations working within it. By 2005 control had been devolved to local authorities and provision became widely varied between localities. This makes large scale outcome evaluation difficult, despite evidence of positive impact locally.

Impoverished children experience higher rates of accidental injury and death[li], chronic disease[lii] and dietary problems such as obesity or malnutrition[liii]. However, 5,500 hospital admissions for deprived children were avoided as a result of Sure Start[liv]. The 'National Evaluation of Sure Start' (2001-2008) found that children involved with Sure Start were less likely to be overweight and had better physical health than those in similarly disadvantaged backgrounds without a local hub. It also revealed that mothers reported a more stimulating and less chaotic home environment, greater life satisfaction, less depressive symptoms and less harsh discipline[lv].

Unfortunately, subsequent impact findings over broader domains have been modest. The 'Evaluation of Children's Centres in England' (2009-2015) found "a number of significant but relatively small positive effects". These evaluative studies should be interpreted in the wider context of their timing, particularly as the latter ran throughout a funding reduction in 2011. Ringfenced funding was lost and the scheme was paid for from an 'Early Intervention Grant' intended to cover all spending on children and young people in the constituency. Funding in real terms for Sure Start children's centres has been cut by 62%, with up to a third of centres closing altogether since 2010[lvi]. There was a lack of guidance from the government regarding Sure Start from 2013[56]. By 2015, Ofsted assessments of the centres were scrapped[56]. In a briefing to the government in 2017, Sure Start was said to have been a net financial loss to the government but "can potentially generate substantial monetary returns over and above the costs of delivering the services"[lvii].

Lessons to be learned from Sure Start include creating clearly defined interventions which can permeate and benefit communities in need, as well as standardized, measurable objectives for service delivery. As the consequences of poverty exist prenatally and continue to manifest throughout childhood, the outcome of such policies can only be definitively established over analysis far longer than the electoral cycle. Cross-party consensus is vital in implementing plans that can be consistently delivered and evaluated, allowing an accurate evidence base to inform future policy and spending. Ringfenced, central funding allows such preventative work to be prioritised in a sea of competing demands and reactive spending. Surely there is a moral imperative to help those in greatest need, even in the absence of overwhelming evidence of scheme efficiency at a national level.

CONCLUSION

Wellbeing is defined by the World Health Organization as "*a state of well-being in which the individual realises their own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and make a contribution to their community"*. It is widely recognised that the path to these outcomes is embedded in the early parent-child relationship. There is greater understanding of the role parents have in promoting healthy brain development, resilience and a child's capacity for learning and emotional wellbeing. The evidence supporting early intervention in the antenatal period has grown significantly since Sure Start was launched and is now overwhelming. Supporting parenting is key to promoting children's wellbeing across their lifetime.

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Medical Student Essay Prize: In these times of widening gaps in society between richer and poorer communities, how can deprivation and poverty affect child mental health?

Ella Sykes

This is not an essay about a clinical case that I came across on placement. It is the story of a child that I lived with for ten months, whom I loved as a brother and whose presence in my life has shaped my understanding of the world monumentally. Mental illness is often a result of numerous interplaying factors, rather than a sudden and spontaneous occurrence, and living with a child whose early life exposure to poverty and deprivation was already manifesting as symptoms of psychiatric disease illustrated this to me more acutely than any statistic or research paper ever could. This is the story of G.

Social and health inequality in the United Kingdom

A boy born into one of England's most deprived areas in 2017 could expect to live to 73.9 years. A boy born at the same time, but in one of the country's least deprived areas, has a life expectancy of 83.4 years, almost a decade longer than his peer[6]. In addition, the proportion of his life that he will spend in ill-health is half that of his more deprived cohort. These inequalities in health are not a new phenomenon, nor are they a fading remnant of historical injustice; to the contrary, a 10-year follow-up to the landmark 'Fair Society Healthy Lives' report (The Marmot Review)[6] found that health inequities between the richest and poorest have increased in the past decade. This is not only a problem for those at the bottom of the pile; people at every rung on the social ladder can expect to live a little shorter than those above them[7].

Mental health and wellbeing are inseparable from the slippery and steepening social gradient in the United Kingdom. Those who are homeless are almost twice as likely as the general population to have a diagnosed mental health disorder[8]; is this because their mental illness caused them to become homeless, or because being homeless led to them developing mental illness? The answer is not straightforward, but the implication is clear; our society is failing those who need our support - to address their mental ill-health, to free them from poverty, or perhaps both – and for none is this more true than for children. The 54-year-old heroin addict living unemployed on the streets can have their lives transformed if given the right help, but the mental ill-effects of years of adversity cannot simply be erased from their existence. A baby born into adversity, however, is not necessarily condemned to this mental 'scarring'; early intervention to reduce their exposure to adverse experiences may drastically alter their life course. Understanding how deprivation and poverty can affect the mental health of children is critical to understanding how we can best intervene and so, as we head into the new decade with health inequalities broadening, the subject of this essay could not be more timely.

Meet G

G came to our family as an emergency foster placement when he was five years and one month old. This came following removal from the care of his mother and subsequent breakdown of his initial foster placement after fewer than two weeks. G's mother, having had previous children removed from her care, had been monitored by social services since G's birth but, other than for a brief period during his infancy, had brought up G independently. She had had several relationships with men other than G's father – from whom she was separated and who has been serving a prison sentence for the duration of G's life – some of whom she had introduced to G. She was not in employment. The primary stated reason for G's removal into social services care was parental neglect.

It is important to mention that G did not have a diagnosed mental illness when he lived with us. At school, and among social workers, there was talk of attention deficit disorders and attachment issues, but he had no clinical labels. In one respect, this may render this entire essay redundant; how can I write about deprivation and mental illness, illustrated by a child without mental illness? But it is precisely because he had no defined problem that I feel he is the perfect case with which to answer the question posed by this essay. Poverty and deprivation do not cause childhood psychiatric disturbance in their own right, but rather they leave a child with a vulnerability to all degrees of mental ill-health which persists throughout their lifetime.

Adverse childhood experiences and neurodevelopment

Adverse childhood experiences, or ACEs, have become something of a buzzword since the term was introduced in the 1990s by the American CDC-Kaiser Adverse Childhood Experiences study[1]. This was the first description of the relationship between exposure to emotional, physical or sexual abuse and/or household dysfunction in childhood and health risk behaviour and disease in adulthood. The study authors reported a graded dose-response between the two factors and developed an ACE Pyramid (Figure 1) to illustrate the way in which ACEs impact health and wellbeing through the lifespan.

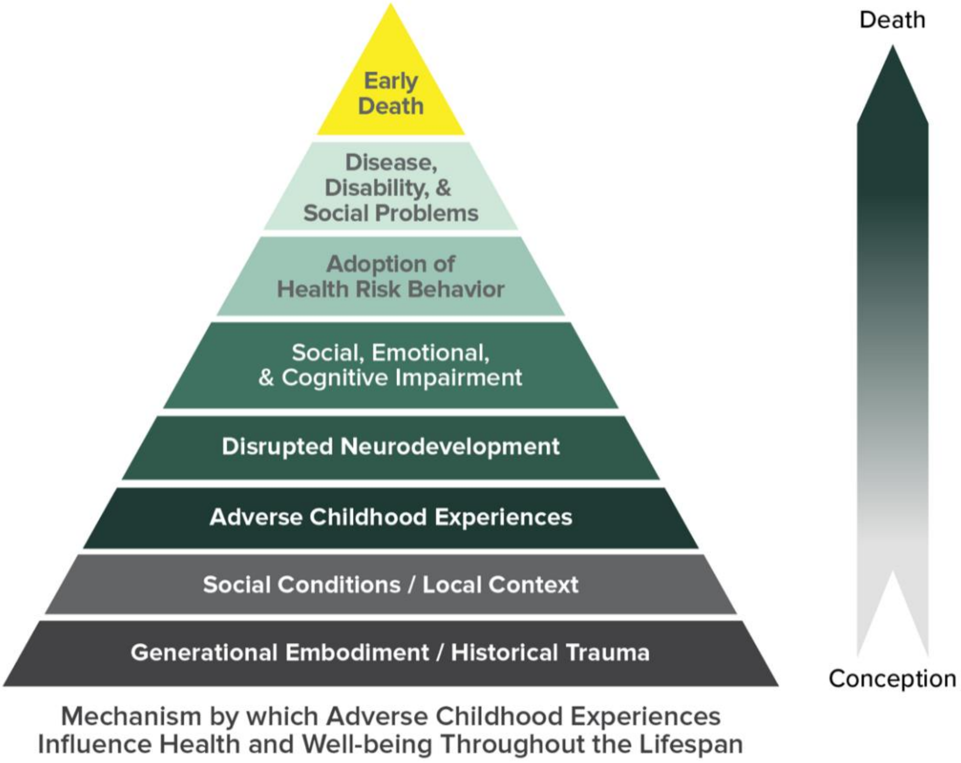

Figure 1

The original ACE study considered the effects of ACEs on adult health and subsequent research, including a 124-study systematic review[10], has established a causal relationship between child maltreatment and mental disorder, drug abuse, suicidal ideation and risky sexual behaviour in adults. However, these effects do not materialise spontaneously during adulthood; children also experience more immediate mental health consequences of adversity. 44% of childhood onset psychiatric disorders can be attributed to adverse childhood experiences[11].

The mechanisms underpinning the relationship between ACEs and mental illness are, at least in part, biomolecular. The early years of life contain the most rapid and most critical periods of development[9], laying the foundations for future physical and psychological wellbeing. With the brain reaching 80-90% of its adult volume by the age of two[12], much attention has been dedicated to the role of ‘sensitive’ and ‘critical’ periods of neurodevelopment in the early years. Sensitive periods are developmental windows of increased neuroplasticity in which specific environmental stimuli, for example exposure to speech, are expected to occur. Failure of the key experience to occur during the sensitive period will impede cortical specialisation, altering the trajectory of future neurodevelopment. Exposure to the stimulus after the sensitive window has passed will still result in development of brain function, but the degree of neuroplasticity will be limited by the lack of initial exposure. Critical period, by contrast, describes those early life experiences which result in irreversible deficits in function if they do not occur within the expected time window; there is no residual plasticity[13].

Environmental input during the first years of life, when these sensitive and critical periods occur, is thus central to sculpting of the central nervous system and so development of cognitive and behavioral functions. In 2010, Clyde Hertzman published a review of his theory of ‘biological embedding’[14]. He identified several pathways by which adverse experiences in childhood may damage physiological systems. The degree of early life stress to which one is exposed conditions the hypothalamo-pituitary-adrenal (HPA) axis, influencing basal cortisol levels. This conditioning, mediated by epigenetic modifications, in turn affects metabolic activity in the brain and other organ systems. The autonomic nervous system, prefrontal cortex executive functions and social affiliation networks (involving the amygdala, locus coeruleus and their regulation by serotonin and other hormones) are all also implicated in the transduction of social experience into biological function. As this essay progresses, I will consider in more depth the effects of specific environmental factors on the developing brain.

Adverse childhood experiences are not a rare occurrence; in England, 46.4% of adults experienced at least one ACE during their childhood[4]. However, distribution of ACEs is not uniform. Frequency is highest in those areas of the country with the highest rates of child poverty[5]. The fact that G, as a child from an area ranked in the top 10% most deprived neighbourhoods in England, had experienced more adversity in five years than I, as the privileged offspring of university-educated parents, had in 17 years, is not coincidental. It is statistically predictable. One could therefore argue that his susceptibility to developing a mental health condition, and indeed the signs of psychiatric disturbance that he was already displaying, were predictable too. Children who fall victim to the widening gaps in inequality in our society are at significantly increased risk of mental ill-health, and so need and deserve our input to help reduce that risk.

Do you love me? Parenting and attachment

The primary reason for G’s admittance into foster care was parental neglect. He had never been bathed in more than a few centimetres of water and consequently was petrified of the bath and having water poured over his head. He had not been toilet trained and was still in pull-ups; this had left him chronically constipated and unable to control his own bowel function. His needs, as a baby and young child, had not been met by his caregiver. Having never observed his interactions with his mother, I cannot fairly comment on their relationship, but the information provided to us by social services strongly suggested that G had not been securely attached to her as a primary caregiver.

Bowlby and Ainsworth’s theory of attachment[30] is a cornerstone of modern developmental psychology. They recognised attachment as a primary motivational force for infants who, evolutionarily, required physical closeness as protection from the threats of predation and exposure. Early interaction between parent and child, whereby the parent is sensitive to the needs of the infant, results in a secure attachment; the adult acts as a safe base from which the infant can explore the world. Failure of this relationship leads to insecure attachment – subcategorised into ambivalent, anxious and disorganised – and children who are less well equipped to cope with the psychological demands of life.

Insecure attachment types have consistently been linked to the development of psychopathology. Insecure-anxious and -ambivalent attachments have been associated with increased risk of anxiety and depression, post-traumatic stress disorder, eating disorders, obsessive-compulsive disorders and suicidal tendencies[32]. Children with a disorganised attachment type – characterised by contradictory, misguided and bizarre behaviour during the ‘strange situation’ test – are more likely to display ‘problem behaviour’ in school and develop dissociative mental illness in adolescence[33].

Problems with attachment, then, are associated with mental ill health in children. But how does this relate to poverty and deprivation, more widely than just my anecdotal experience with G? Insecure attachment is often linked to maltreatment of children[31], and children growing up in the lowest socioeconomic groups are reported to experience abuse and neglect at five times the rate of other children[34]. Ergo, impoverished children are at increased risk of suffering the psychological ill-effects of poor attachment. To assume that all low-income parents are abusive and neglectful would be wildly unjust. But even in households without evidence of maltreatment, children exposed to five or more socioeconomic risk factors (such as low household income, single parenthood, adolescent motherhood) are no less likely to display disorganised attachment behaviours than abused or neglected children. In other words, being deprived in itself may be just as damaging to a child as being maltreated[31].

G may have been left vulnerable to mental illness by his poor attachment to his mother, but that is not to say that she was a 'bad mum'. To the contrary, I believe that she was trying her best to provide for her young son and looked after him as well as she knew how. G arrived with a list, handwritten by his mother, of the things he enjoyed. Most of what she had listed applied better to a toddler than to a boy of five yet, much more importantly, the very fact she had written it showed that G's mum had cared for her son, that she had taken interest in him and had tried to understand what he liked and didn't.

Parenting, though I cannot speak from personal experience, is challenging whatever your circumstances. But parents of low-income families are more likely to be dealing with the additional stresses of marital conflict and/or lone parentship, problem debt, drug and alcohol dependency and poorer mental health[39]. Their ability to devote time, care and attention to their child's development is impeded, even in those with the most loving intentions. An American study in 2003 illustrated this well; researchers found that the children of families on welfare had 30 million fewer words addressed to them in the first four years of their lives than did the children of professional parents. When the welfare family children were addressed, the language used was more often negative and prohibitive[40]. With multifarious additional stresses demanding their attention, parents living in deprived circumstances can lack even the mental capacity to engage with their children.

Maternal depression is just one example of those external factor which can negatively impact on the ability to parent. Mothers in low-income families are almost twice as likely to develop depression than those in higher income brackets, a risk which increases if the woman is a single parent[36]. Depression is characterised by persistent low mood, anhedonia and anergia, so it is hardly surprising that mothers who are depressed are more likely to act in a negative, hostile and disengaged way towards their offspring. As a consequence, their children have increased incidence of internalising and externalising disorders, anxiety, poorer interpersonal skills, a more negative affect and lower self-worth than children of non-depressed parents[37].

Growing up in deprivation and poverty, then, often means living in a household with parents who are unable to devote the attention to attachment and development that more privileged children experience. Consequently, even if not psychologically unwell, these children grow up less mentally healthy – in terms of attachment, cognitive ability, self-worth and affect – than their peers.

Food for thought: malnutrition and the developing brain

G was malnourished when I first met him. He wasn't severely underweight, but his anxious little face was pinched and pale and, when we undressed him for a bath, his ribs protruded conspicuously.

Alongside the list of things he liked, G’s mother had provided a list of his favourite foods; chicken nuggets, fish and chips, biscuits and sweeties. All foodstuffs probably favoured by most typical five-year-olds if given the choice, but it quickly became apparent that this was pretty much the extent of G’s diet.

Malnutrition in childhood is not a trivial issue in the United Kingdom. According to a 2017 UNICEF report[17], 19% of children in the UK live in households which are moderately or severely ‘food insecure’. This makes it the fourth worst-performing nation in the European Union for this measure. Low-income households have not only the worst food insecurity, but also the lowest intake of fruit, vegetables and key nutrients, and the highest free sugar consumption[18]. With the scarcest availability of ‘healthy’ food[19] and highest density of takeaway food outlets[20] found in the most deprived areas of the country, these results are hardly surprising. Children living in poverty in the UK are at risk of both low overall intake (undernutrition) and macro- and micronutrient deficiencies, which may manifest in a healthy- or overweight child with a nutrient-poor diet.

Both forms of malnutrition are linked to abnormal neurodevelopment. There is strong evidence for a causal relationship between early childhood macronutrient (glucose, protein and fat) undernutrition and mental disruption; underfed children have poorer cognitive function and IQ, and increased behavioural problems[22]. The exact mechanisms for this relationship are complex and not fully understood, though animal studies have shown undernutrition to cause diminished neural cell proliferation, reduced dendritic complexity and delayed metabolic maturation of brain tissues[23]. Lack of key nutrients, such as zinc, iron and omega-3 fatty acids, has been linked to disruption in synthesis and function of neurotransmitters, including serotonin and dopamine, implicated in depressive and behavioural disorders[21]. In childhood, when sensitive and critical periods of neurodevelopment are ubiquitous, the brain is particularly vulnerable to these deficiencies and damage may not be reversible with subsequent improvements in nutrition. A 2011 review found that iron deficiency in infancy caused long-term cognitive and socio-emotional behavioural deficits; adolescents with iron-deficiency anaemia which was corrected during infancy show demonstrate more anxious-depressive symptoms than their never-deficient peers[24]. Children living in poverty are being literally starved of the opportunity for their brain function to develop healthily.

Food insecurity in deprived households does not only cause neurological disturbance through malnutrition; living in an environment in which food is a rare commodity also causes psychological damage. G’s attitude towards food was almost obsessive; he would consume meals with a sense of desperation, as if the plate would be taken away from him if he didn’t eat quickly enough. This is something I have observed among many of the foster children we have looked after, across a whole spectrum of body weights.

Several papers have described this behaviour scientifically. In 1994, Ayoob et al coined the term ‘nonobese hyperphagia’; a syndrome of active searching for food and excessive, insatiable appetite not leading to obesity, which they linked to placement in foster care[27]. Similarly, Tarren-Sweeney described a ‘food maintenance syndrome’, characterised by over-eating, hoarding and stealing food[28], prevalent among fostered children. Data for why these syndromes present in looked after children is limited, but one may hypothesise that exposure to a food insecure environment prior to being brought into care (though not the case universally, these households are more likely to be deprived and so food-limited[2]) contributes to possessive eating behaviours once the child is in a home where food is more readily available. Their early life experiences have conditioned them to hold on to whatever food they can get.

Living in a food insecure environment has also been linked to more generalised socio-emotional behavioural problems. Children who are clinically 'hungry' show increased aggressive and anxious behaviours[25]. When controlled for cofounders, children from food insecure households were twice as likely to exhibit persistent symptoms of hyperactivity and inattention than those who are not food insecure[26]. In summary, children growing up in deprived families whose access to food is inadequate are at increased risk of abnormalities in mental function which may contribute to the development of psychiatric disorders.

It's all about the money: poverty and life experiences

My memories of childhood consist mainly of family bike rides on Sunday afternoons, of walks in the park and splashing in muddy puddles, of baking fairy cakes and begging to lick out the bowl, of long days spent building sandcastles on the beach and bedtimes tucked up with my dad reading a story in his best funny accent. To my privileged mind, that was what childhood was. But G showed me a wholly different reality.

In the first few days of being with us, he would squint when he went outside because he wasn't used to the brightness of sunlight. He had no idea how to ride the little bike we had at the back of our garage, although within weeks he was angling for the stabilisers to come off so he could pedal faster, and when we took him to the beach we realised that he had never seen the sea before. The concept of sitting still while we ate at a restaurant was alien to him, and he refused to ride on the mini railway train we took him to as he was so unsure of what it was. In short, his experience of the world was upsettingly narrow.

In 2017/18, 1.6 million children in the UK were living in households which were not only low-income, but classed as 'materially deprived', meaning they lacked the ability to access key goods and services[29]. These children are less able to attend organised clubs and activities outside of school, pursue hobbies, take holidays away from home or celebrate special occasions in the way that their more affluent peers may take for granted. And the research shows that it is primarily financial strain, rather than a fundamental difference in the priorities of parents, which deprives poorer children of these experiences. As the wealth of low-income families increases, they tend to spend a greater proportion of their income on items which will improve the experiences of their children - books, family holidays, children's footwear and transport – and less on tobacco and alcohol[41].

The consequences of material deprivation in childhood are not purely materialistic. The presence of developmentally appropriate books, toys and games in the home facilitates optimal cognitive development in the early years[28]. Involvement in extracurricular activities – many of which require parents to pay - is associated with improved optimism, satisfaction with life, self-image and sense of peer belonging in children[42]. Children growing up in homes in which these educational materials and socially enriching experiences are financially unachievable are thus unable to benefit from the positive impact they have on mental health and wellbeing. During the summer holidays, lower income children experience more loneliness, hunger and reduced physical activity, and this is correlated with poorer mental wellbeing on their return to school[39]. Growing up poor is detrimental to a child's mental health because their world is smaller; the lack of ability to pay for life experiences means their opportunities to develop mentally protective attributes such as self-confidence, resilience and a sense of peer belonging are restricted. The saying "money can't buy you happiness" is not inaccurate in principle, but it cannot be overlooked that a financially stable upbringing affords children a degree of protection against mental ill-health that their less affluent peers cannot access.

Looked after children

G was, and still is, a looked after child. I don't believe it is helpful to perpetuate the stereotype that children in care are 'messed up' but, drawing upon my own experience living in a fostering family, I have never met a looked after child who didn't suffer significant behavioural and emotional disturbance. Moving beyond the anecdotal evidence, looked after status is independently associated with almost all types of neuropsychiatric disorder[3]. Those disorders in which environmental factors are thought to play a leading role, including post-traumatic stress disorder (PTSD) and conduct disorders, show the strongest associations with being in the care system. Younger children, such as G, are more likely to have oppositional defiant, hyperkinetic and/or separation anxiety disorders than older looked after children, who more commonly present with anxiety and depressive disorders and PTSD.

The reasons for the increased prevalence of mental ill-health among looked after children are perhaps self-evident; in 2018-19, the most common primary reason for a child being taken into care was abuse or neglect, followed by chronic family dysfunction[15]. These in themselves constitute adverse childhood experiences, and when compounded by the attachment disorders discussed above, which have increased prevalence in looked after children (only 10% of children brought into care have a secure attachment to their biological parents[16]), it is no surprise that these children are particularly susceptible to mental health problems.

This essay is about poverty and deprivation, not looked after children. However, the positive association between level of neighbourhood deprivation and proportion of looked after children is extremely strong. A child living in the most deprived 20% of neighbourhoods in England is 9 times more likely to be under local authority care than one living in the least deprived areas[2]. Therefore, the unique experiences of this group of children cannot be overlooked in a conversation about deprivation and childhood mental illness.

Closing thoughts

My coverage of child mental illness in this essay has been broad and non-specific; I have mentioned many disorders but explored none in depth. But this is unapologetically so, because this messiness, this bombardment with wide-ranging contributors to psychological damage, accurately reflects the mental state I saw in G. He is not a child with a specific mental illness which can be explored in light of his deprived and impoverished background. Rather, the experiences of that deprived and impoverished background are so deeply ingrained into his neurology – his behaviours, personality and perceptions of the world – that the mental health which he experiences in the rest of his life, whether pathological or not, will be inseparable from his start in life. Though the right support can minimise the damage, the mental consequences of adversity in childhood are irreversible.

Happily, however, they are preventable. The need for us to lessen the gap between the richest and poorest in society is indisputable on a multitude of grounds, many of which were elegantly described by Michael Marmot in 2010[6]. But it has been 10 years since his landmark review, and in that time rates of childhood poverty in the UK have increased. By allowing the gaps to widen, we are allowing children like G (of whom there are many; in 2017/18, 4.1 million children in the UK were living in relative low-income households after housing costs[29]) to come into the world disproportionately vulnerable to mental illness. Admittedly, in this essay I have not considered the significant role of genetics in the development of mental ill health; but genetic factors influence susceptibility to disease between individuals, not between socio-economic groups. To argue that deprived children are three times more likely to develop a severe mental illness than those in the highest quintile of income[35] because of their genetics alone would be ludicrous. These differences exist because of a society which we have created, and that we are maintaining through inaction. I hope that within my lifetime we, as a nation, are able to make paradigm changes to the socioeconomic divisions within our society, and see these changes positively reflected in the mental health of all of our children.

POST-SCRIPT:

In an essay about how childhood experiences shape neurodevelopment, it cannot be ignored that G played a role in the sculpting of my own cognition and behaviour. At 17 years old, I was in the formative adolescent stages of neuroplasticity when he lived with us, and as such the understanding of early life experience and deprivation that I gained from him will have altered my perception of the world enduringly. It is because of him that I was attracted by the title of this essay competition, and because of him that I will carry a special interest in the mental health of deprived young people through my career in medicine. This essay is dedicated to him, the little brother I never knew I needed.

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Minimum age of criminal responsibility: Time for a raise?

Susan Walker

Minimum age of criminal responsibility: Time for a raise?

The RCPsych is planning to develop a position statement on the minimum age of criminal responsibility. This will be led by the adolescent forensic psychiatry SIG, who recognise that this is an issue that spans multiple disciplines and want to draw on all available expertise within the college and beyond. Here I briefly summarise some of the history and key issues about the minimum age of criminal responsibility, and invite members of the CAP faculty to submit views on this subject to Stella Galea who has kindly agreed to collate these (Catherine.Langley@rcpsych.ac.uk).

The minimum age of criminal responsibility (MACR) is the age below which a person is deemed not to have criminal responsibility, and above which they can be prosecuted in the criminal justice system, which can include being tried in an adult court. International human rights standards provide that a minimum age of criminal responsibility should be specified, and the UN Convention on the Rights of the Child has encouraged member states to adopt a minimum age of no less than 14 years, and has commended those with higher ages such as 15 and 16.[1] However, there remains wide international variation in the MACR.

In Scotland, the MACR was raised from 8 to 12 last year. In England, Wales and Northern Ireland the MACR has been 10 since it was raised from 8 in the Children and Young Person's Act 1963.[2] Along with Switzerland where the MACR is also 10, this is the lowest in Europe. The average MACR in Europe is 14.

Raising the MACR in the UK is a controversial issue. Following the conviction of two 10-year-old boys for the murder of James Bulger in 1993, a more punitive stance towards children who offend was established, with the aim of "nipping youth crime in the bud".[2,3] In the Crime and Disorder Act 1998, the principle of *doli incapax* (the notion that children aged 10-13 may not understand that what they had done was seriously wrong, a defence which could result in acquittal), which had afforded children additional legal protection in the UK since the 14th century, was abolished.[2] This highlights how politicised and complex the issue has been.

However, significant advances in neuroscience over the last two decades, as well as inconsistencies in the way in which young people are treated in civil and criminal law, all support the need to review the MACR. There is also a concern that the low age of criminal responsibility in the UK may be disproportionately affecting children and young people from Black and minority ethnic groups (BAME) who, in 2019, were found to represent the majority (51%) of young people in custody in England and Wales for the first time.[4]

Previously, it was believed that the first 5-8 years of childhood were the most critical period for brain maturation and that, once this period had passed, there was relatively little subsequent brain development. However, we now know that brain development continues into our twenties and that the pre-frontal cortex, which is involved in decision-making, planning, inhibiting inappropriate behaviour, social interaction and self-awareness, is the slowest to develop.[5] We also know that adolescent brains differ from adult brains in the way the reward systems are activated with respect to risk, meaning that adolescents are more likely to take risks, are more prone to impulsivity, less capable of emotional reasoning and more likely to make errors in self-regulation. Risk taking is even more likely in the presence of other adolescents and in situations of high arousal, which is often the context in which criminal behaviour occurs.[6,7] Modulating arousal, resolving conflict, decision-making, impulse control, taking time to assess a situation, making a plan and acting on it with full knowledge of the potential consequences, all require a mature pre-frontal cortex.[8]

In addition, many children in contact with the youth justice system have experienced Adverse Childhood Experiences (ACEs) such as early life trauma and abuse. We now know that any ACE can lead to brain structure abnormalities associated with heightened risk taking and difficulties with emotional regulation, and greatly multiplies the risk of being involved in criminal behaviour.[9–11] It is also now understood that there is a high prevalence of young people with (often previously undiagnosed) neurodevelopmental disorders such as autism and ADHD in the criminal justice system.[12]

Therefore, neurodevelopmental evidence raises clear questions about whether it is appropriate to treat anyone aged 10 or above equally in terms of clinical responsibility, and suggests that it may be difficult to prove 'beyond all reasonable doubt' that a child or adolescent has full criminal responsibility for their actions.

In order to be found guilty of a crime, a person has to have both committed the criminal act (*actus reus*) and been aware at the time that it was not only seriously wrong, but criminally wrong (*mens rea*). Currently, therefore, a 10 year old in England is deemed to have a level of moral reasoning sufficient to prove that they possess *mens rea*, but is not thought able to make an informed decision about many other issues, arguably with much less serious or long-term outcomes. For example, a 10 year old is not able to vote in an election, get married, join the army, buy cigarettes, alcohol, or even take responsibility for a pet.[13] The fact that children aged 10 to 16/17 are recognised as having capacities that differ from those of adults in civil law, but not in criminal law is incongruous and suggests that children in trouble with the law are held to a different level of accountability to other children. This is even the case within criminal law itself where child witnesses are afforded a level of protection and support that is not routinely offered to children accused of offences.[14]

Alongside discussion about raising the MACR, alternative ways to manage young people who commit offences will also need to be carefully considered. It will be important to acknowledge that if the MACR is raised, young people who offend will not go unpunished, rather that this will be done outside of the criminal justice system. The goals of an alternative system would include the prevention of early criminalisation which, instead of 'nipping crime in the bud', has been found in longitudinal research to be frequently associated with further criminal behaviour in adulthood;[13] flexible sentencing options; effective rehabilitation interventions; and ensuring that young people who commit serious crimes and potentially pose a risk to the public have access to suitable secure placements. Recognising the rights of the victims of crime and maintaining public trust in the criminal justice system are also both important considerations. It is possible that we could learn from other countries with similar systems, who have already negotiated these difficulties.[15]

1. United Nations. *Convention on the Rights of the Child: General comment No. 24 on children's rights in the child justice system*. http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsqIkirKQZLK2M58RF%2F5F0vEnG3QGKUxFivhToQfjGxYjV05tUAIgpOwHQJsFPdJXCiixFSrDRwow8HeKLLh8cgOw1SN6vJ%2Bf0RPR9UMtGkA4 (2019).
2. Delmage, E. The Minimum Age of Criminal Responsibility: A Medico-Legal Perspective. *Youth Justice* (2013) doi:10.1177/1473225413492053.
3. Lord Williams of Mostyn. *Youth Justice: White Paper*. https://api.parliament.uk/historic-hansard/lords/1997/nov/27/youth-justice-white-paper (1997).
4. Youth Justice Board / Ministry of Justice. *Youth Justice Statistics 2018/19*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862078/youth-justice-statistics-bulletin-march-2019.pdf (2020).
5. Gogtay, N. *et al.* Dynamic mapping of human cortical development during childhood through early adulthood. *Proc. Natl. Acad. Sci. U. S. A.* (2004) doi:10.1073/pnas.0402680101.
6. Blakemore, S. J. The social brain in adolescence. *Nature Reviews Neuroscience* (2008) doi:10.1038/nrn2353.
7. Blakemore, S. J. & Choudhury, S. Development of the adolescent brain: Implications for executive function and social cognition. *Journal of Child Psychology and Psychiatry and Allied Disciplines* (2006) doi:10.1111/j.1469-7610.2006.01611.x.
8. Pillay, A. L. The minimum age of criminal responsibility, international variation, and the Dual Systems Model in neurodevelopment. *Journal of Child and Adolescent Mental Health* (2019) doi:10.2989/17280583.2019.1692851.
9. De Brito, S. A. *et al.* Reduced orbitofrontal and temporal grey matter in a community sample of maltreated children. *J. Child Psychol. Psychiatry Allied Discip.* (2013) doi:10.1111/j.1469-7610.2012.02597.x.
10. McCrory, E. J. *et al.* Amygdala activation in maltreated children during pre-attentive emotional processing. *Br. J. Psychiatry* (2013) doi:10.1192/bjp.bp.112.116624.
11. English, D. J., Widom, C. S. & Brandford, C. *Childhood Victimization and Delinquency, Adult Criminality, and Violent Criminal Behavior: A Replication and Extension, Final Report. Final report presented to the National Institute of Justice under grant 97-IJ-CX-0017* (2002).
12. Hughes, N. *Neurodisability in the youth justice system: recognising and responding to the*

criminalisation of neurodevelopmental impairment. https://howardleague.org/wp-content/uploads/2016/04/HLWP_17_2015.pdf (2015).

13. Goldson, B. 'Unsafe, Unjust and Harmful to Wider Society': Grounds for Raising the Minimum Age of Criminal Responsibility in England and Wales. *Youth Justice* (2013) doi:10.1177/1473225413492054.

14. Vizard, E. *Child Defendants, Occasional Paper OP56*. http://www.michaelsieff-foundation.org.uk/content/Relevant Report 2 - RCP - Child Defendants Report March 2006.pdf (2006).

15. Adolescent Forensic Psychiatry SIG. *Additional Submission to Justice Select Committee | Inquiry into children and young people in custody*. (2020).

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Pointers on Parents Under Pressure

Margaret Thompson

In October 2019, Professor Edmund Sonuga-Barke (Kings College, London) was awarded a NIHR programme Grant to build on the online version of the of the New Forest Programme which had been trailed as part of a previous NIHR programme development grant. The research team included parenting researchers from the Universities of Kings, Southampton, Nottingham and the Solent NHS Trust. Me Health developed by Johnny Downs (Kings College) will be the online recruitment platform for a RCT which begins soon In Southampton, Nottingham and SLAM CAMHS clinics.

The team worked with a web-based platform called TOAD (Henry Waterfall-Allen, Digital Director) as the web platform for the STEPS' programme.

During the course of the work on developing the new programme, to be called STEPS, the COVID-19 pandemic arrived and clearly with lock down approaching and nurseries and schools shutting, many parents with young children would find life even more of a challenge whatever their child's temperament.

The research team therefore decided that it would be good to develop a shortened version for parents to give them ideas to help them with behavioural strategies for making life more bearable with their lively and maybe bored children.

This was written as a series of tips for parents based on the STEPS programme.

It can be accessed from https://www.kcl.ac.uk/pointers-on-parenting-under-pressure-pop-up

At the same time material was also developed for professionals with ideas and strategies to assist parents presenting with behavioural problems. This can be accessed from the ACAMH website.

https://www.acamh.org/blog/helping-parents-manage-challenging-behaviour-during-the-covid19-lockdown-some-pointers-for-practitioners/

As well as these Tips for parents, Edmund, with a grant from the SLaM/Maudsley Charitable Trust, drafted a new series of 8 scripts from material in POPUP and in consultation with other colleagues with expertise in parenting. He commissioned Henry and his colleagues (from TOAD) to transfer the written material to eight short videos. These are very entertaining cartoons which illustrate the problems and strategies. Well-known actors **(**Romesh Ranganathan, Shappi Khorsandi, Rob Brydon, Danny Dyer) and actresses **(**Jessica Ennis-Hill**,** Holly Willoughby Sharon Horgan, Olivia Colman) agreed to do the voice overs.

The videos can be accessed from **www.familiesunderpressure.org**

On behalf of the POPUP team

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Peer Group Meeting by Skype

Kate Robertson, Lynn Brown and Amna Malik

To use the Royal College of Psychiatrists' CPD submission programme to demonstrate good standing for CPD, non-training grade psychiatrists must be 'active members of a peer group which meets at least 4 times a year', which peer group 'is responsible for allocating CPD credits to learning activity and must be assured that development and appropriate reflection has taken place'. College guidance states that video-conferencing should be considered where there are geographical constraints on meeting. (References OP98, BJPsych Advances (2016), vol. 22, 269–276 doi: 10.1192/apt.bp.114.013920).

At a time of massive service change, the use of teleconferencing for social, professional, and clinical purposes has skyrocketed. This makes it an interesting time to reflect on our experiences of conducting peer group meetings over Skype, which we started in 2017, in response to challenges in establishing a peer group whilst locuming, and one of us moving abroad. Three of the four members are now in substantive posts, and we work in Ireland, Scotland, and Saudi Arabia.

Peer groups fulfil a range of functions, from meeting College guidance regarding oversight and sanctioning of CPD, to providing a safe and supportive environment in which to reflect on professional life and practice, with relationships developing over time. Members may be friends, but the focus of a peer group is professional, aimed at helping members develop, learn, and continually improve their practice.

The first challenge is technology: we have become resigned to the vagaries of the internet, and can function voice only, although it is definitely nicer to see people's faces. The boundary between personal and professional lives needs to be maintained, somehow, despite dogs, children, partners, parents and pets, and it is odd to arrive suddenly in another person's house, which can feel friendly but also intrusive. This improves with practice, and familiar places to sit and talk from; as we are child psychiatrists, the occasional incursion of small children is a blessing rather than a curse.

Unexpected benefits include the insight gained on the cultural and social constraints, and strengths, arising from different locations and cultures of work. Similar professional backgrounds provide one layer of context; we all trained in child psychiatry in the UK, although via slightly different routes. Case discussions have been fascinating, highlighting context and culture in the presentation of each child and family, as allowing us to gain understanding of different models of service delivery. We have begun to develop a 'feel' for one another's practice and attitudes and respect the different perspectives each brings to discussion. Differences allow us to question our own unchallenged beliefs and assumptions. The wealth of CPD resources found internationally has been mind-broadening; virtual meetings allow for immediate sharing of papers and resources, and shared conference feedback gives us information and insight from a wider range of sources than any one of us could have managed individually.

In the time of Covid, WhatsApp groups have proliferated and ameliorated personal and social isolation. But the benefit of regular professional meetings with people known and trusted, in a familiar format, has been invaluable. We already had the baseline understanding of one another's professional lives which allowed us to discuss, appreciate, and reflect on the massive impact Covid has had, disproportionally on BAME psychiatrists and their families, but also on all of us as psychiatrists and human beings. We have discussed the challenges of running a Balint group by videoconference, patients attending appointments from their bedrooms whilst still in bed, working from home or continuing to attend clinics and hospitals, and how all these things make us feel. Having met up in this manner over time, and not having had virtual meetings imposed on us by the pandemic, makes our meetings feel more robust, less forced, than all the other video calls that now take up such a large part of our working lives. And, of course, we discuss and approve CPD, because that is what we are for. But an established virtual peer group provides much more than this, and at times during the pandemic a safe professional space to think and learn has felt like a lifeline. This raises the potential for expansion of virtual meetings to include formal peer supervision, mentoring and support, and Royal College encouragement regarding this possibility would be welcome.

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Feasibility and usability for an objective test of typical ADHD symptoms (QbCheck) when performed in children outside the clinic: A service evaluation

Pennine Care NHS Foundation Trust (Greater Manchester)

ADHD objective measurements can be a highly valuable complement to an ADHD clinical interview (1-3). Currently, all the community CYPMH services in Pennine Care NHS Foundation Trust (PCFT) routinely use QbTest as part of the clinical assessment for ADHD alongside NICE recommended guidance.

However, it is not always possible to bring patients into the clinic for assessment. This is more relevant in the current COVID-19 context where it has not been feasible to undertake routine QbTest clinics leading to delays in the assessment of ADHD in children and young people within services.

The use of online assessments could be an alternative to overcome this problem. QbCheck is an on-line test that measures all three cardinal symptoms of ADHD. The test can be performed on a personal computer with a web-camera and an internet connection. A recent study used QbCheck to objectively assess for ADHD symptoms in the patient's home environment. The results showed that QbCheck has good psychometric properties and acceptable usability in adolescents and adults (5). QbCheck has been introduced in some school settings, including within Greater Manchester (Tameside) but has not been widely implemented.

Therefore, during COVID, PCFT senior management team proposed to utilise QbCheck as an alternative to Qbtest across 4 boroughs (Bury, Oldham, Rochdale, and Stockport) as part of a service evaluation.

The aim of this service evaluation is to evaluate: 1) Technical feasibility - this will be measured by looking at the frequency of tests that were initiated at the QbCheck website and that resulted in valid test reports. 2) Practical feasibility - this will be measured by looking at the frequency of children/caregivers instructed to perform a QbCheck at home and that managed to initiate the test at the QbCheck website. 3) Usability of QbCheck from the child/parent perspective. This will be measured by using a metric-based feedback after the test-taker has finished the test. 4) Usability of QbCheck from the clinician/administrator perspective. This will also be measured using a metric-based feedback. 5) Preliminary validity data for the different psychometric variables in the test measured as discriminant validity vs final clinical outcome. 6) Preliminary validity data for the subjective rating scale items that are incorporated into QbCheck test.

Children and adolescents (6-17 years) that are subject for an ADHD assessment and in the possession of a computer with a web camera and an internet connection are taking part in this evaluation. The exclusion criteria are: 1) Previous diagnosis of ADHD, 2) Concurrent clinical diagnosis that could affect test performance (neurological disorders, psychosis or other neurodevelopmental disorders including moderate LD or ASD), 3) Concurrent prescription medicines for ADHD that significantly could affect test performance (e.g., neuroleptic, and antiepileptic drugs) and 4) Poor English skills that may influence consent or implementation of the test.

To perform the test on the QbCheck website, eligible patients/caregivers are receiving a voucher code by the participating clinic. The website is self-explanatory, it includes instructions to prepare for the test and check for camera accuracy. Before performing the test, caregivers fill out a subjective symptom rating scale based on the DSM-5 criteria. This scale is incorporated into the QbCheck online-test and includes similar questions to other validated ADHD subjective rating scales.

After performing the test, the test-taker/caregiver is filling out a questionnaire that asks questions about the online-test experience. Similarly, to evaluate the clinical staffs experience, a specific feedback form will be filled in during the service evaluation.

This pilot service evaluation commenced on 26th May and it is expected to end at the end of September 2020 but could be extended.

10. References

1. Vogt, C., & Shameli, A. (2011). Assessments for attention-deficit hyperactivity disorder: Use of objective measurements. *Psychiatrist, 35*(10), 380-383. doi: 10.1192/pb.bp.110.032144

2. Hall, C., Selby, K., Guo, B., Valentine, A., Walker, G. (2016). Innovations in Practice: an objective measure of attention, impulsivity and activity reduces time to confirm attention deficit/hyperactivity disorder diagnosis in children– a completed audit cycle. *Child And Adolescent Mental Health, 21*(3), 175-178. doi: 10.1111/camh.12140

3. Hollis, C., Hall, C., Guo, B., James, M., Boadu, J., Groom, M., & … Morriss, R.(2018). The impact of a computerised test of attention and activity (QbTest) on diagnostic decision-making in children and young

people with suspected attention deficit hyperactivity disorder: Single- blind randomised controlled trial. *Journal Of Child Psychology And Psychiatry And Allied Disciplines*. doi: 10.1111/jcpp.12921

4. NICE guideline 2018. Attention deficit hyperactivity disorder: diagnosis and management. Available at: https://www.nice.org.uk/guidance/ng87.

5. Ulberstad, F., Boström, H., Chavanon, M. L., Knollman, M., Wiley, J., Christiansen, H., Thorell, L. B. (2020). Objective measurement of attention deficit hyperactivity disorder symptoms outside the clinic using the QbCheck: Reliability and validity. *International Journal of Methods in Psychiatric Research.* Advanced online publication doi: 10.1002/mpr.1822.

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Could Music be an Answer to COVID-19 Related Problems?

Sitki Anil Ustun

Quarantine life has caught almost all of us so unprepared. Now we have absorbed the news and accepted this very new fact of our lives, we have been trying to adapt to the new circumstances.

In response to the pandemic, various public health strategies such as isolation of infected or at-risk persons, reduction of social contact, have been advised to reduce the risk of infection. Although these measures have been successful with a significant decrease in growth rate and increased doubling time of cases, reduced access to family, friends, and other social support systems causes loneliness and increasing mental issues like anxiety, depression as well as increase in substance use. (1)

But what if most of these problems could be solved or eased with one significant factor and that was music?

Music has been used for treatment purposes since the earliest times. Over the centuries there have been many concepts regarding its functional mode, like ancient concepts, and recently influencing the physiological functions of organisms. A scientific basis for music therapy only emerged after World War II and the term "music therapy" was introduced in about 1950. It complements pharmacotherapy as a part of complex treatment, together with other forms of art therapy, psychotherapy, and physiotherapy. (2)

The way music has been practised since the pandemic has evolved in many ways. Excitingly awaited concerts and events had to be cancelled, consequently, some have been performed in remote settings. Although these have given a sense of artificiality, it has become accessible to so many people across the world which also enhanced the audience of the performances and therefore the bond by the music. Despite these changes, music has still been very accessible to everyone across the globe and that could be utilized to address the problems occurred and aggravated by pandemic circumstances.

Initially public emotional response to any pandemic is of extreme fear and uncertainty which usually drives towards negative societal behaviours and can involve public mental health concerns like anxiety, insomnia, depression aggression, frustration and hysteria (3)

Furthermore, exposure to situations capable of generating post-traumatic stress disorders, such as natural disasters (earthquakes, pandemics) or accidents, has been associated with increased rates of alcohol abuse and dependence in some studies (4). Research conducted by Alcohol Change UK revealed that around one in five drinkers (21%) told us that they have been drinking **more frequently** since the lock-down. This suggests that around **8.6 million UK adults** are drinking more frequently under lock-down. (5)

Parents and caregivers are attempting to work remotely or unable to work, while caring for children, with no clarity on how long the situation will last. For many people, just keeping children busy and safe at home is a daunting prospect, especially when living with increased stress, media hype, and fear, all of which are challenging our capacity for tolerance and long-term thinking. (6)

Evidence shows that violence and vulnerability increase for children during periods of school closures associated with health emergencies. Rates of reported child abuse rise during school closures. For many, the economic impact of the crisis increases parenting stress, abuse, and violence against children. (6)

The music experiences used in music therapy may be varied and can range from listening to music to playing or singing songs to free improvisation.

When the outcomes of studies in music therapy analysed, many promising results addressing the problems exacerbated in the pandemic circumstances are seen. In a randomised controlled study, participants receiving music therapy plus standard care showed greater improvement than those receiving standard care only in depression symptoms, anxiety symptoms and general functioning at 3-month follow-up. (7) Moreover, another study addressing more severe anxiety disorders; in patients with OCD, music therapy, as an adjunct to standard care, seems to be effective in reducing obsessions, as well as co-morbid anxiety and depressive symptoms. (8)

In a study comparing the effects of music therapy interventions on depression, anxiety, anger, and stress specifically in a group with alcohol use disorder; participants' scores in depression, anxiety, anger, and stress were significantly reduced after participating in the music therapy sessions. (9) Furthermore, other study results indicate that personally pleasing music might have a role in augmenting substance use disorder treatment via craving reduction. (10)

Musical activities were used to promote positive parent—child relationships and children's behavioural, communicative, and social development. Significant improvements were found for therapist-observed parent and child behaviours, and parent-reported irritable parenting, educational activities in the home, parent mental health and child communication and social play skills. (11)

The relationship between music and social bonding has been an interest of research. Although there is as yet no consensus about the mechanisms, two main theories of synchronization and EOS (the endogenous opioid system) have been widely accepted. Synchronization is often cited as an important mechanism by which social bonding can occur. (12) Endorphins (and the EOS in general) are involved in social bonding across primate species and are associated with a number of human social behaviours (e.g., laughter, synchronized sports), as well as musical activities (e.g., singing and dancing).

It is well known that passively listening to music engages the EOS(12). In a recent study analysing the audience and a violinist in a violin performance concluded that it is highly possible that neural synchronization between performer and audience occurs when they are engaged in the same music performance. Furthermore, the popularity of the performance and music appreciation were also correlated with the left-temporal inter-brain coherence (IBC) between the audience and the violinist. (13) Those research data suggest that the EOS and synchronisation are important in the social bonding effects of music which could be experienced in the music events and performances.

In conclusion, music stands as an inexpensive and widely accessible tool for everyone who has been mentally affected by the pandemic. In the pandemic circumstances music and music events have evolved in the positive way. Therefore, music remain as a perfect aid and even solution for not only to the exacerbated problems by the pandemic, but in our daily lives.

References:

1 - Zhou et al., 2020. Zhou X., Snoswell C.L., Harding L.E., Bambling M., Edirippulige S., Bai X., and Smith A.C.: The role of telehealth in reducing the mental health burden from COVID-19. Telemed. E-health 2020; undefined

2- Shiranibidabadi, Melina; Mehryar, Amirhooshang (2017) "Music therapy as an adjunct to standard treatment for obsessive compulsive disorder and co-morbid anxiety and depression: A randomized clinical trial": Corrigendum Journal of Affective Disorders; Nov 2017; vol. 222 ; p. 40

3- Shigemura J, Ursano RJ, Morganstein JC, Kurosawa M & Benedek DM: Public responses to the novel 2019 coronavirus (2019-nCoV) in Japan: mental health consequences and target populations. Psychiatry and Clinical Neurosciences, 2020

4- Boscarino, J. A., Adams, R. E. & Galea, S. (2006). Alcohol use in New York after the terrorist attacks: a study of the effects of psychological trauma on drinking behaviour. Addictive Behaviours, 31, 606-621. doi:10.1016/j.add-beh.2005.05.035.

5- Lebeaut, A., Tran, J. K. & Vujanovic, A. A. (2020). Post-traumatic stress, alcohol use severity, and alcohol use motives among firefighters: The role of anxiety sensitivity. Addictive Behaviours, 106, 106353. doi:10.1016/j.add-beh.2020.106353.

6- Alcohol Change UK, Press Release, New research reveals how UK drinking habits have changed during lockdown, April 2020

7- Cluver, Lucie; Lachman, Jamie M.; Sherr, Lorraine; Wessels, Inge; Krug, Etienne et al. (2020)

Parenting in a time of COVID-19 The Lancet; Apr 2020; vol. 395 (no. 10231); p. e64

8- Erkkilä, J., Punkanen, M., Fachner, J., Ala-Ruona, E., Pöntiö, I., Tervaniemi, M., Gold, C.(2011). Individual music therapy for depression: Randomised controlled trial. British Journal of Psychiatry, 199(2), 132-139.

9- *Dobrzyńska, Ewelina; Cesarz, Helena; Rymaszewska, Joanna; Kiejna, Andrzej (2006) Music Therapy--history, definitions and application Archives of Psychiatry and Psychotherapy; Mar 2006; vol. 8 (no. 1); p. 47-52*

10- A comparison of the effects of music therapy interventions on depression, anxiety, anger, and stress on alcohol-dependent clients: A pilot study Hwang, Eun-Young; Oh, Sun-Hwa Music and Medicine; Jul 2013; vol. 5 (no. 3); p. 136-144

11- The acute effect of pleasurable music on craving for alcohol: A pilot crossover study.

Mathis WS; Han X Journal of psychiatric research; 2017; vol. 90 ; p. 143-147
12- Nicholson, J. M., Berthelsen, D., Abad, V., Williams, K., & Bradley, J. (2008). Impact of Music Therapy to Promote Positive Parenting and Child Development. Journal of Health Psychology, 13(2), 226–238.

13- (Tarr B, Launay J, Dunbar RI. Music and social bonding: "self-other" merging and neurohormonal mechanisms. Frontiers in Psychology. 2014 ;5:1096.

14-Yingying Hou, Bei Song, Yinying Hu, Yafeng Pan, Yi Hu (2020) The averaged inter-brain coherence between the audience and a violinist predicts the popularity of violin performance NeuroImage, 211,

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Talking to psychiatrists in North West Syria

Dr Taghrid Tahoun

‘Yatiki elafyeh doctora’, ‘Bless your health doctor‘, said kind voices. travelling miles from the beautiful, war torn region of North West Syria. Less than ten psychiatrists still practice in the region, few were in training when the war started. They are serving nearly five million people. Few psychiatrists are also still working with a great number of refugees in Southern Turkey. The World Health Organisation’s Mental Health and Psychosocial Support Programme (MHPSSP) is working to support local mental health services and practicing doctors. They were looking for help around child and adolescent psychiatry, and I was privileged to use my knowledge of Arabic and of the topic to answer the call.

Our talk aimed to give an overview of child and adolescent psychiatry. The doctors seemed to also need a practical guide to case formulation. We discussed a case, made complex by the social and cultural considerations involved in supporting the parents of a hyperactive child. Discussing this case, we thought creatively about solutions. It is important to remember that in the UK, we are privileged by an abundance of guidance, large peer groups and established primary and social care networks. This means that we have specialist input in multiple fields. This is not the case in many parts of the world, and many doctors need to wear multiple hats. I had this experience in working abroad and can relate to this scope of practice. The thoughts that we exchanged, were a great opportunity for mutual learning.

Our colleagues in Syria are currently practicing against a backdrop of significant challenges. From this experience, I can identify two hurdles for their continued development in child psychiatry specifically. Firstly, access to the knowledge base and resources; Syria remains the only Arab country, as far as I know, that has committed to an Arabic medical education, and there is a shortage in Arabic child psychiatry resources. The language barrier can limit doctors' access to guidance, and specialist assessment tools. Secondly, it can impact on the consistency of peer support. More than anything, the group wanted to discuss complex cases. Like any of us, they need an accessible specialised forum to discuss cases, and to find practical advice. Language and cultural aspects would need to be considered in facilitating this meaningfully. The MHPSSP is working diligently to fill the gaps, and they aim to prioritise children's mental health.

This link with our colleagues in Syria is a great opportunity for shared growth, and there is plenty that can be offered to support their work, and to aid the outreach of our specialty. This is especially significant as the college launches its first International Strategy this year. On a personal level, this experience has enriched my practice, and reminded me to maintain the diversity of my skill set. It was sobering to consider what this group of colleagues might have gone through personally in this war, while they continue to fulfil their duties as doctors. It can be easy to get carried away in life, and it is important to stay mindful of one's drivers as a doctor. I was glad to hear that the group found our talk useful, and to receive an invitation back from the programme. I am looking forward to what this experience brings.

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Coronavirus through the eyes of a Core Trainee

Eileen Moss

The last six months have been a very challenging time for everyone working in healthcare. In February 2020, I started my first ever placement in Child and Adolescent Psychiatry at Massereene House in the Northern Health and Social Care Trust in Northern Ireland. This was something that I had been very much looking forward to- I had always been intrigued by this branch of Psychiatry ever since I had started Core Training. The first six weeks of my placement were dynamic and interesting. I learnt about the diagnosis and management of conditions such as ADHD and Attachment Disorders in children. I also got the opportunity to work in a team with many different healthcare professionals who each brought their own unique skills to patient interactions. Unfortunately, after six weeks it became clear that the Coronavirus pandemic was going to significantly alter the working patterns of everyone in the team that I was working in.

From mid-March 2020, most of the contact that I had with my patients was over the telephone. This was a new way of working for me and it was something that I did not have much experience of. I became very aware of the positives and negatives of this way of working as time progressed. Much to my surprise, I discovered that some patients actually preferred to be reviewed over the telephone. I found that (in general) patients who suffered from anxiety disorders preferred this way of working. However, telephone reviews weren't accepted by everyone. I found that some patients preferred being reviewed via video calls. This medium presented challenges to me in terms of making sure that patient confidentiality was always maintained.

I feel that the negatives of telephone reviews became very clear to me even after only reviewing a handful of patients in this way. Firstly, for patients with ADHD, it is important to monitor their physical parameters (height, weight, pulse and blood pressure) regularly. This was not possible to do over the telephone. Furthermore, the appearance element of the mental state examination is impossible to complete over the telephone. The final thing that I noted was that a lot of patients did not want to have changes in their medications made or new medications started without having a face-to-face consultation with a doctor.

In summary, the last six months have been an extremely difficult period for everyone but especially for those working in healthcare. I think before the Coronavirus pandemic, I had very much under-estimated the extent of how much patients appreciate face-to-face contact with the clinicians who are treating them. I think being able to build a good rapport with a patient is essential to providing them with the highest standard of care possible. Furthermore, as doctors I think we can make more accurate diagnoses and better management plans when our patients are sitting in front of us. I look forward to the day when face-to-face contact for all patients will become the norm again.

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Building Children's Resilience in the face of Parental Mental Illness – Conversations with Children, Parents and Professionals

Edited by Alan Cooklin and Gill Gorell Barnes

Forewords by Alastair Campbell and Professor Kim Foster

Children living with parents with a mental illness are often invisible, voiceless and experience complex home lives often assuming added responsibilities and caring for their parents.

It has been estimated by The Children's Commissioner for England that there are 3.7 million children living with a parent with either moderate or severe mental illness in this country.

I was extremely interested when this book came out, and when I glanced with great curiosity at the list of contributors it was refreshing to see something I do not often see in other books. The list of authors who have helped to create the book are from diverse sociodemographic backgrounds with both experts in their professional fields, and most importantly we have the voices of experts of experience.

This is a book which has been co-produced with three groups of people in mind. Firstly, we have the young people growing up with a parent with mental illness, then the parents who experience mental illness and the professionals seeking to help one or both of these family members and address inter-generational challenges which mental illness can contribute to.

Each chapter is insightful, written with great understanding and depth and as I moved onto reading the young people's chapters, I could hear the voice of each child's experience loud, present, and clear. My understanding of the book is the important message that young people with parents who have been mentally ill, benefit from three ingredients, which have been delivered through the Kidstime Foundation -

1. To know that they are not alone,

2. To have a neutral, relatively uninvolved advocate and

3. To have a decent explanation of what is happening when their parent becomes ill.

For me, the most interesting chapters were written by the young people who were able to describe their life experiences – guilt, shame, stigma, rejection, and blame, including the impact on their own mental health. Rather than blaming parents, there is a clear message of how young people can make sense of their experiences and move on with their lives. There is considerable conversation and dialogue, and one hopes that this will help to continue to open up conversations which need to happen in the wider societal context.

From a practical perspective, there is an excellent section on combined tips at the end of the book along with recommended training resources. I found the book accessible and informative, and this will be a resource which I will dip into. The book will be helpful to those working across health, social and educational settings and I will be gifting it to some of my adult mental health and social care colleagues too.

Review written by Dr Fareeha Amber Sadiq, Consultant Child and Family Psychiatrist

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Autumn Leaves

Dr Bloster

Dr Bloster: Les Feuilles Mortes 16.Oct 2020

Late on a Friday afternoon in clinic, I am musing on the sadness all around us and wondering why the world hasn't got better as I had expected it to. When I started in child psychiatry, 20 years ago, there was a sense of real optimism that we could achieve social change and improve children's mental health. Instead there appear to be enormous numbers of young people presenting with advanced mental illness. Community CAMHS and hospital A&E's have struggled to meet the need and specialist services have found it hard to meet the high levels of demand. Covid is just the last straw for many people. As people working with families and between agencies, we have to face patient and staff distress and anger as their lives become harder.

People in the general hospital are anxious, tired and thinking about change. Management and NHS direction seem puzzling and out of touch, a reflection of the lack of leadership at the very top. Service are contracted out and the workable cases cherry-picked by privately contracted services. At this time, when weariness sets in, I strongly recommend listening to Edith Piaf's Autumn Leaves (Les Feuilles Mortes) on You Tube. Her powerful voice full of Gallic passion and mournful regret is strangely cheering.

In CAMHS and in paediatric services, we have lost staff who have gone to help with the covid cases affecting adult services and staff who are shielding. Our clinicians and administrative staff have been fantastic in keeping the services going. I made a referral to Milton Keynes today- well done that cheery and effective person on the other end of the phone! Our teams need gathering up. Even virtually we can create an atmosphere of togetherness and hope. Our solidarity will help our patients and families to manage. Supporting each other and not getting split has now become our civic duty. It has never been a better time to show our value as clinicians and our staying power. So, all of you, listen to some Edith Piaf, feel strong in spite of all the difficulties and never underestimate how important you are and of course ‘Moi je ne regretted rien!’.

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Association of Child and Adolescent Mental Health – A digest of the published work of Michael Rutter 1958 – 2020 – by Jim Stevenson, Psychology, University of Southampton

Review by Prof Elena Garralda

Review for the Newsletter for the Child and Adolescent Faculty of RCPsych

Elena Garralda, Emeritus Professor of Child and Adolescent Psychiatry, Imperial College London -- October 2020

The Associations for Child and Adolescent Mental Health (ACAMH) has published a digest of all the papers authored or co-authored by Professor Sir Michael Rutter and published in peer reviewed journals until 2020: a total of 540 papers and 52 books! The digest is available to ACAMH members as a downloadable PDF. It has been collated by Jim Stevenson, Emeritus Professor of Developmental Psychopathology at the University of Southampton, himself a child psychologist with an illustrious academic career.

Michael Rutter has long been recognized as a pivotal figure in the field of child and adolescent psychiatry and developmental psychopathology. After medical training at the University of Birmingham he specialised in psychiatry and became the first person to be appointed professor of child psychiatry in the United Kingdom. Alongside running a child psychiatric clinic at the Maudsley Hospital, he developed a pioneering and impressive academic and research body of work. This was recognized internationally and lead amongst many other awards and honours to a number of honorary degrees from universities all over the world.

A central aspect of his scientific work was its adherence to rigorous principles, quoted in the digest as an acknowledgement of science as *“consisting of both discovery and proof, hypothesis and then* *careful testing to discriminate between alternative hypotheses".* This has had a profound influence on academic child psychiatry in this country and beyond.

The digest includes very helpful commentaries and summaries of the different and numerous areas covered, presented in an alphabetical order. The range is clearly considerable and broad and covers individual disorders such as autism, broader issues in the way of classification and links between child and adult disorders, but also prominently biological and specially psychosocial influences, in addition to the research methodology underpinning much of the work. Along the way Jim Stevenson provides synopses and illuminating quotes highlighting key aspects of the work. Although the digest focuses on scientific achievement, the relevance of clinical experience and its interplay with research is reflected in the following quote in the context of research on autism:

"*Many key advances were prompted by astute clinical observations and some extravagant research claims were given a more balanced perspective through the light of clinical experience*."

This digest represents a unique and welcome opportunity for the younger generation of child psychiatrists to become familiar with the approach and wealth of knowledge arising out of Michael Rutter's contribution. I can see it becoming a *must have* in the digital library of every child psychiatrist and expect it will continue to influence aspiring academics in the field.

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Book Review: 'Night Philosophy' by Fanny Howe

Jane Whittaker

I do not really "do" poetry. Not for any particular reason. Keats for "O" level was not especially traumatic. But it was hard, and, for me, poetry still is. I am never sure whether you read it in your head, or out loud. It sounds different depending on how you attack it. And you cannot read it quickly, like you can skim the dull bits in a novel. On the other hand, poetry can also be thought provoking, powerfully emotional and can hold a moment. Manchester's Tony Walsh perfectly captured the mood when he recited "This is the Place" in the aftermath of the Manchester Arena bombing in May 2017.

Even in the lockdown enforced, socially distanced, binge reading of the COVID-19 era I have stuck to short stories, novels, literary reflections, and history. So, to come across a review about a small collection of poetry, musings and poetic prose fragments by Fanny Howe that I really wanted to try to read is unusual even in these unusual times. That the Times Literary Supplement review piece was written by Chris Kraus (I Love Dick, Aliens and Anorexia) made it even more compelling.

Fanny Howe is now in her 80's. She has been writing and teaching for decades. She is a Euro-American, married to, then divorced from an African-American and has successful author (adult) children. In Kraus's review Kraus cites Howe's remarks to a radio host about having her children.

"My interior life is now fully identified with people on another side of history than the one I was raised in. And so, there is no way of turning back after that. What you carry physically inside of you can't be distinguished from what you carry psychically" (in the TLS 10th July 2020).

This is certainly evident in this collection, created in the shadow of 2019 and the policy of separating South American children from their families who were trying to reach the USA. It was published just as the Covid pandemic began to bite, differentially targeting some parts of our communities and some of our colleagues more than others. We now have our summer of George Floyd and the "Black Lives Matter" movement and the scandal and tragedy that this still needs to be explicitly stated. Howe rages against the (mis)treatment of people who are other than white, and who are vulnerable, children, refugees and survivors with her own words and pieces selected from other writers. They are fragmented, baffling and beautiful.

Books have a physical shape, they start at one point and move in physical space from right to left as the reader turns the page, whilst the narrative the creates an internal journey. This book has a conceptual shape, with the section that reprints the United Nations Declaration of the Rights of the Child as the centre and the other pieces in the book fanning out like petals around a flower. It is disorienting.

One of the early entries should grab Child and Adolescent Psychiatrists; a short prose piece about a girl and her psychiatrist (p3). The prose is written in sparse, precise language, creating whole characters in tiny sentences. I will not spoil the ending, but the punch line is brilliant. We should all read it. "Doctor, Doctor" (p72) sits about halfway through the book and speaks of an adult thinking back to childhood whilst talking to her psychiatrist. And towards the end of the book "The Pest" is about suicide and what drives the young to commit suicide, describing it as "a surge of unhope" (p82).

"A Useful Man "(p6) describes Jaques Lusseyran's experience of going blind as a child and his later life. "The Plant" describes the experiences of two teenage sisters, taken from Poland in the Second World War to work as slave labourers in a Nazi factory. It reflects on the urgency of their need to covertly, and at great risk, write poetry in the camp about the horror of their experiences and their reflections on their poems later in life. It articulates sensation of looking at events in childhood through the lens of adulthood and how foreign that can feel. It reminds us that we only see children through their own words with all the limitations of those voices and voiceless-ness. Later recollections are through the prism of adult mind.

A section called "Wonders" reflects on child trafficking, slavery and abuse (p66) Despairing, "Children cry even when there is no-one to hear them" and hopeful "If children have a chance to remember and report a painful event they have a chance at recovering" (p67).

“1922” presents thoughts on Simone Weil (1909 -1943), French mystic and philosopher who was curiously prone to fasting and of interest to those with an interest in eating disorders and novelists like Chris Kraus. Starting with some of Wiel’s own musings it summarises her short life and the impact of her relationship with her mathematician brother during their childhoods.

Psychiatrists have long been interested in subjective accounts of experiences of mental disorder and trauma. Literature helps us with this and there is always the possibility that the well written fiction is crafted from personal experiences of those who are creative enough describe them. Edited by Femi Oyebode, the wonderful “Mindreadings” (2009) covers the value of written form to psychiatrists. It includes chapters on mental disorders in literature and the intimate, inner experiences of psychosis, depression, personality disorder and dementia. It has a chapter on representations of the challenges of representing the voice of people with learning disability. But there is nothing on children, their voices or how their experiences are told for them by adults. This little book does. Treat this book like a rather expensive box of rich chocolates; one at a time, take it slow, appreciate the moment.

References

1. Kraus C (1997) I Love Dick. Pub: Serpent's Tail (5 May 2016)
2. Kraus C (2000) Aliens and Anorexia. Pub: Tuskar Rock (14 Jun. 2018)
3. Kraus C (2020) Wandering and Wondering: Fanny Howe’s philosophy of childhood. Time Literary Supplement July 10
4. Oyebode, F (ed) (2009) Mindreadings: Literature and Psychiatry. Cambridge University Press.
5. Walsh, T. “This is the Place” https://www.youtube.com/watch?v=PszMmYpQjPo

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Building Children’s Resilence in the Face of Parental Mental Illness

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Conversations with Children, Parents and Professionals

Edited by Alan Cooklin and Gill Gorell Barnes

When parents suffer a mental illness, their children face multiple challenges. They manage stigma, self-doubt and self-blame, ongoing anxiety and depression. These issues are rarely talked about in the public domain. In 2018 the Children’s Commissioner for England estimated that 3.7 million children lived with a parent with mental illness.

This important new book, written from their different perspectives, focuses on the relationships between children and young people, parents and professionals and their emotional and life issues, and gives action points which promote resilience in the children.

Parental mental illness has been identified as a key Adverse Childhood Experience (ACE), but the small interventions described in the book, given at the right time, can make significant differences, both in the present and future lives of children and parents.

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Blackpool sixth form debate: This house believes that school is good for mental health (January 2020)

Alison Flynn and Gabrielle Pendlebury

On Thursday 30th January 2020, The Blackpool Sixth Form College hosted the second Young People's Mental Health Debate to be held on the Fylde Coast. Expertly chaired by Dr Virginia Davies, of The Royal College, our enthusiastic students debated the motion "This House believes that school is good for mental health". The debate was a result of the continuing collaboration between Blackpool Sixth, Blackpool Teaching Hospitals, Blackpool CAMHS and Blackpool Council. The first successful debate, held at the college in November 2018, considered the motion. '"This house believes that social media is bad for your mental health".

To increase participation from the previous event, the sides this time were made up of teams of students who worked together to research and construct their arguments, whilst benefiting from the support of mental health professional from the Royal College and the local community mental health service staff.

Prior to the debate, local organisations hosted stands in the College's foyer, to raise awareness of the support and opportunities available for young people in our local area. Head start, Entwined Minds, Minds Matter, Blackpool CAMHS and UR Potential all engaged with student and visitors, discussing the challenges young people face and the help available. Both teams presented well-researched thought-provoking arguments. The green team, formed by four sixth form students, debating FOR the motion, considered the role of schools in facilitating the five ways to wellbeing, including connecting with like-minded individuals and pastoral support, the benefit of learning to boost mental wellness and the extra-curricular opportunities education can provide.

The red team, consisting of five sixth form students, debating AGAINST the motion focused on the negative impacts of exam stress on mental health, bullying in schools and the lack of curriculum focus on creative subjects and general life skills. The team used some persuasive statistics to support his point of view.

After delivering their arguments the panels opened up to questions from the floor. The audience, challenged the panel with some tricky queries and challenged points already made. It was impressive to see the students deal with these in a calm and professional manner. Special note was also made that one of the local school's pupils not only attended the debate, but had discussed the topic prior to the event.

Voting was done using red and green cards held by audience. The initial and final vote showed a clear majority were against the motion. It was noted the number in majority did shift a little in the final vote. Clearly some audience had been persuaded that schools can indeed be of benefit to the mental health of young people.

From the post-debate feedback, it was clear that the staff and students who attended really enjoyed the debate. Several teachers commented that they were proud of the maturity and passion displayed by their students and the buzz continued into the lessons that followed.

Blackpool Sixth would again like to thank the Royal College of Psychiatrists for their patronage of the debate, and to Dr Virginia Davies for travelling from London to be our Chair. The student speakers appreciated the kind words and praise she sent them following the debate. Finally, thanks to Dr Vasu Balaguru, who has been the driving force behind both debates. The students, and the College have really appreciated the opportunities.

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References for the Sure Start Essay

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[i] WHO ‘Promoting mental health : concepts, emerging evidence, practice : summary report / a report from the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne.’ Geneva, World Health Organization 2004

[ii] ‘Report of the UK Children’s Commissioners, UN Committee on the Rights of the Child Examination of the Fifth Periodic Report of the United Kingdom of Great Britain and Northern Ireland’; 2015

[iii] Costello, E.J., Compton S.N., Keeler G., Angold A., ‘Relationships Between Poverty and Psychopathology: A Natural Experiment.’ *JAMA:* 2003;290(15):2023–2029.

[iv] Wickham, S., Anwar, E., Barr, B., et al., ‘Poverty and child health in the UK: using evidence for action.’ *Archives of Disease in Childhood:* 2016;101:759-766.

[v] Buss, C., Entringer, S., Swanson, J.M., Wadhwa, P.D., ‘The Role of Stress in Brain Development: The Gestational Environment's Long-Term Effects on the Brain. *Cerebrum*: 2014; 4. Epub 2012 Apr 25. PMID: 23447790; PMCID: PMC3574809.

[vi] Altenhöner, T., Köhler, M., Philippi, M., ‘The Relevance of Maternal Socioeconomic Characteristics for Low Birth Weight - a Case-Control Study’. *Geburtshilfe Frauenheilkd*. 2016;76(3):248–254. doi:10.1055/s-0042-100204

[vii] Douglas, Hazel., ‘Supporting emotional health and wellbeing: the Solihull Approach.’ *Community practitioner: the journal of the Community Practitioners' & Health Visitors' Association*: 2010; 83. 22-5.

[viii] Fonagy, P., Steele, M., Steele, H., Moran, G. S., & Higgitt, A. C., ‘The capacity for understanding mental states: The reflective self in parent and child and its significance for security of attachment.’ *Infant Mental Health Journal* 1991; 12(3), 201–218.

[ix] Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. ‘Affect regulation, mentalization, and the development of the self.’ *Other Press*: 2002

[x] Mikic, N., Terradas M., ‘Mentalization and attachment representations: A theoretical contribution to the understanding of reactive attachment disorder.’ *Bulletin of the Menninger Clinic* 2014: Vol. 78, No. 1, pp. 34-56. https://doi.org/10.1521/bumc.2014.78.1.34

[xi] Fonagy, P., & Allison, E., ‘The role of mentalizing and epistemic trust in the therapeutic relationship.’ *Psychotherapy*: 2014; 51(3), 372-380. doi:10.1037/a0036505

[xii] Fonagy, P., & Luyten, P., ‘A multilevel perspective on the development of borderline personality disorder.’ In D. Cicchetti (Ed.), *Developmental psychopathology*: 2016; Vol. 3: Risk, disorder, and adaptation (3rd ed., pp. 726-792). New York, NY: John Wiley &Sons.

[xiii] Fonagy, P., Luyten, P., & Allison, E., ‘Epistemic petrification and the restoration of epistemic trust: A new conceptualization of borderline personality disorder and its psychosocial treatment.’ *Journal of Personality Disorders:* 2015; 29(5), 575-609. doi:10.1521/pedi.2015.29.5.575

[xiv] Weinberg, M.K., Beeghly, M., Olson K.L., Tronick E., ‘A Still-face Paradigm for Young Children: 2½ Year-olds' Reactions to Maternal Unavailability during the Still-face.’ *J Dev Process*: 2008;3(1):4–22.

[xv] Goodman, A., Gregg P., et al., ‘Poorer children’s educational attainment: how important are attitudes and behaviour?’ *Joseph Rowntree Foundation*: 2010

[xvi] Schools Analysis and Research Division, ‘Deprivation and Education: The evidence on pupils in England, Foundation Stage to Key Stage 4’*, Department for Children, Schools and Families*: March 2009

[xvii] Clegg N, Allen R, Fernandez S, Freedman S, Kinnock S. ‘Commission on Inequality in Education’. *Social Market Foundation*; 2017

[xviii] Education in England: Annual Report 2019, *Education Policy Institute;2019*

[xix]Katz, I., Corlyon, J., La Placa, V., Hunter, S., ‘The relationship between parenting and poverty’, *The Joseph Rowntree Foundation*; 2007

[xx] McCord J., ‘Coercion and punishment in long-term perspectives.’ Cambridge: *Cambridge University Press*; 1995

[xxi] Caspi, A., Moffitt, T.E., Morgan, J., Rutter, M., Taylor, A., Arseneault, L., et al. ‘Maternal expressed emotion predicts children’s externalizing behavior problems: Using MZ-twin differences to identify environmental effects on behavioural development.’ *Developmental Psychology*. 2004;40:149–161

[xxii] Kenrick, D. T., Griskevicius, V., Neuberg, S. L., Schaller, M., ‘Renovating the Pyramid of Needs: Contemporary Extensions Built Upon Ancient Foundations.’ *Perspectives on psychological science : a journal of the Association for Psychological Science*:2010; *5*(3), 292–314. https://doi.org/10.1177/1745691610369469

[xxiii] J. Lawrence Aber, J., Bennett Dalton, N.G., Conley Jiali Li, C., ‘The Effects of Poverty on Child Health and Development’ *Annual Review of Public Health*: 1997; 18:1, 463-483

[xxiv] Belsky, J., ‘The Developmental and Evolutionary Psychology of Intergenerational Transmission of Attachment’. (2005) In C. S. Carter, L. Ahnert, K. E. Grossmann, S. B. Hrdy, M. E. Lamb, S. W. Porges, & N. Sachser (Eds.), *Attachment and bonding: A new synthesis* (p. 169–198). MIT Press.

[xxv] Mikulincer, M., & Shaver, P. R., ‘An attachment perspective on psychopathology.’ *World psychiatry : official journal of the World Psychiatric Association (WPA):* 2012; 11(1), 11–15. https://doi.org/10.1016/j.wpsyc.2012.01.003

[xxvi] Grief et al. ‘The Human Cost. An overview of the evidence on economic adversity and mental health and recommendations for action’. Dublin: Mental Health Commission: 2011

[xxvii] Björkenstam, C., Kosidou., Björkenstam, E., ‘Childhood adversity and risk of suicide: cohort study of 548 721 adolescents and young adults in Sweden’ *BMJ:* 2017; 357 :j1334

[xxviii] Dube S.R., Anda R.F., Felitti V.J., Chapman D.P., Williamson D.F., Giles W.H., ‘Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span: Findings From the Adverse Childhood Experiences Study.’ *JAMA.* 2001;286(24):3089–3096. doi:10.1001/jama.286.24.3089

[xxix] Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C. and Lowey, H. ‘National Household Survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England’. *BMC Medicine*: 2014; 12(72).

[xxx] Bellis, M. A., Ashton, K., Hughes, K., Ford, K., Bishop, J., and Paranjothy, S., ‘Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population’. Cardiff: *Public Health Wales*: 2015

[xxxi] Burke, N. J., Hellman, J. L., Scott, B. J., Weems, C. F. and Carrion, V. C., ‘The Impact of Adverse Childhood Experiences on an Urban Paediatric Population,’ *Child Abuse and Neglect*:2011; 35 (6).

[xxxii] Felitti, M.D., Anda, R.F., Nordenberg, M.D. et al., ‘Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study’ *American Journal of Preventative Medicine:1998;* 14.

[xxxiii] Bellis, M.A., Hardcastle, K., Ford, K. *et al.,* ‘Does continuous trusted adult support in childhood impart life-course resilience against adverse childhood experiences - a retrospective study on adult health-harming behaviours and mental well-being’. *BMC Psychiatry*:2017; 17, 110 https://doi.org/10.1186/s12888-017-1260-z

[xxxiv] Crouch, E., Radcliff, E., Strompolis, M. et al., ‘Safe, Stable, and Nurtured: Protective Factors against Poor Physical and Mental Health Outcomes Following Exposure to Adverse Childhood Experiences (ACEs)’. *Journ Child Adol Trauma: 2019;* 12, 165–173 https://doi.org/10.1007/s40653-018-0217-9

[xxxv] Murali, V., & Oyebode, F., ‘Poverty, social inequality and mental health’. *Advances in Psychiatric Treatment: 2004; 10*(3), 216-224. doi:10.1192/apt.10.3.216

[xxxvi] ‘Saving Lives: Our healthier nation’, *Department of Health*: 1999

[xxxvii] Health and Social Information Centre, ‘Health Survey for England’ *Social Care Statistics*: 2009

[xxxviii] Mental Health Statistics; Poverty, Mental Health Foundation https://www.mentalhealth.org.uk/statistics/mental-health-statistics-poverty (accessed 30/01/20)

[xxxix] Walker, E., Kestler, L., Bollini, A., Hochman, K.M., ‘Schizophrenia: Etiology and course’. *Annual Review of Psychology*: 2004;55:401–430

[xl] Hood, A., Waters, T., ‘Living standards, poverty and inequality in the UK: 2017–18 to 2021–22’, *The Institute for Fiscal Studies:* 2017

[xli] Levin, K. A., Currie, C. & Muldoon, J., ‘Mental well-being and subjective health of 11 to 15-year-old boys and girls in Scotland, 1994–2006’ *European Journal of Public Health:* 2009;19, 605–610

[xlii] Hagell, A., ‘Time Trends in Adolescent Wellbeing Update December’ Changing Adolescence Programme, Nuffield Foundation: 2009

[xliii] Cohen, P., Chen, H., Gordon, K., Johnson, J., Brook, J., Kasen, S., ‘Socioeconomic background and the developmental course of schizotypal and borderline personality disorder symptoms’. *Dev Psychopathol*. 2008;20(2):633–650. doi:10.1017/S095457940800031X

[xliv] Elliott, I. ‘Poverty and Mental Health: A review to inform the Joseph Rowntree Foundation’s Anti-Poverty Strategy’. London: *Mental Health Foundation*: 2016

[xlv] Farrington, D. P., ‘The development of offending and antisocial behaviour from childhood: key finding from the Cambridge Study in Delinquent Development’ *Journal of Child Psychology and Psychiatry:* 1995, 36, 929–964

[xlvi] Brandt, D.E., ‘Delinquency, development, and social policy.’ New Haven, CT: *Yale University Press*; 2006

[xlvii] Hirsch, D., ‘An estimate of the cost of child poverty in 2013’ Loughborough University Centre for Research in Social Policy *Child Protection Action Group*: 2013

[xlviii] https://cpag.org.uk/news-blogs/news-listings/child-poverty-working-families-rise (accesed 09/03/2020)

[xlix] Lee. K., ‘Effects of experimental center-based child care on developmental outcomes of young children living in poverty.’ *Social Service Review*: 2005;79:158–180

[l] ‘Governance Guidance for Sure Start Children’s Centres and Extended Schools’, *Department of Education and Skills*: 2007

[li] The Children’s Society., ‘A good childhood for every child? Child Poverty in the UK’. *The Children’s Society:* 2012

[lii] Marmot, M., Allen, J., Goldblatt, P. et al., ‘Fair society, healthy lives: strategic review of health inequalities in England post 2010.’ *Marmot Review Team*: 2010

[liii] Joseph Rowntree Foundation. ‘The costs of child poverty for individuals and society’. *Joseph Rowntree Foundation*: 2008

[liv] Cattan, S., Conti, G., Farquharson, C., Ginja, R., ‘The health effects of Sure Start,’ *The Institute for Fiscal Studies*: June 2019

[lv] The National Evaluation of Sure Start Research Team ‘The Impact of Sure Start Local Programmes on Three Year Olds and Their Families’ National Evaluation Summary: 2008

[lvi] Smith,G., Sylva,K., Smith,T., Sammons, P., Omonigho, A., ‘STOP START Survival, decline or closure? Children’s centres in England, 2018’ *The Sutton Trust*: 2018

[lvii] Sammons,P., Hall,J., Smees,R., Goff,J., Sylva,K., Smith,T., Evangelou M., Eisenstadt,N., Smith,G., ‘Evaluation of Children’s Centres in England’ (ECCE, Strand 4), Research Brief *Department for Education*: 2015