Written evidence submitted by the Association of Child and Adolescent Mental Health (EYI0070)

Executive summary

- There is a strong link between experiencing childhood adversity and lifetime risk for mental illness.

- Children who experience adversity are often exposed to multiple forms of adversity and not just one.

- There is strong evidence of a dose dependent association, such that the accumulation of multiple Adverse Childhood Experiences (ACEs) is associated with greater risk of negative long-term outcomes.

- The evidence derived from following-up a group of children over years cannot be combined with that derived from speaking to a group of adults about their childhoods, as these two approaches detect largely different groups of victims.

- Children with maltreatment histories are complex: a traditional focus only on diagnostic categories can obscure the complexity of needs, which often include attachment issues, sub-threshold symptomatology, placement factors, and educational needs - all of which have to be addressed.

- Treatment for children who experience maltreatment and adversity is very poor in two respects. First, current mental health provision fails to meet the complex needs of this group, who do not easily fit within a simple diagnostic framework. Second, we have no current evidence-based approaches to measure or target latent vulnerability by providing preventative help that could reduce the risk of future mental health problems and promote a resilient outcome.

- In light of this, effective screening and generalised preventative measures to avoid the development of mental health problems in the first place should be an important research and clinical priority.

- A treatment model where the young person is at the centre of decision-making is likely to work best and will ensure they can be active partners in shaping the care that they receive. In this way, help follows needs rather than diagnostic categories.

- Multidisciplinary events and networks of academics and professionals working in this area can be beneficial in translating the best contemporary evidence into clinical practice.

- A central body, representing the diversity of expertise required to address the issue of ACEs, is required to co-ordinate and prioritise funding efforts effectively.
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Introduction

1. This submission has been prepared on behalf of The Association of Child and Adolescent Mental Health (ACAMH), a multidisciplinary membership organisation promoting an evidence-based approach to young people’s mental healthcare. The submission was written by Ben Upton, with contributions from Dr Andrea Danese, Senior Lecturer and Consultant in Child & Adolescent Psychiatry at King’s College London, and Prof Eamon McCrory, Professor of Developmental Neuroscience and Psychopathology at UCL.

2. Our submission focuses on maltreatment of children by adults (abuse, neglect) or victimisation by peers (bullying). We will also touch upon the broader issue of Adverse Childhood Experiences (ACEs), which also includes household problems (parental separation, mental illness in household, criminal household member, household substance abuse).

Evidence base for the effects of maltreatment

3. There is a large literature relating to the effects of child maltreatment, with the majority of studies either forward or backward-looking. Forward-looking or ‘longitudinal prospective’ studies seek children exposed to adverse experiences, following them as they grow up to measure outcomes. Backward-looking or ‘cross-sectional retrospective’ studies seek adults and generally ask them to recall childhood adversities at the same time as outcomes are measured. The outcomes measured can include illnesses or symptoms, both mental and physical, or may include broader ramifications, such as economic productivity (Currie and Widom, 2010).

4. The two parts of the literature are often combined, but there are concerns about doing so as there is quite limited overlap between the groups of individuals detected by either approach (Reuben et al., 2016). Therefore, integrating the results of both types of design is unlikely to be a valid way of summarising the evidence available in the literature.

5. However, both prospective and retrospective studies have independently shown broad associations between adverse childhood experiences and negative outcomes in later life (Danese and McCrory, 2015). In terms of mental health, maltreatment is related to quite a broad range of psychiatric outcomes including depression, anxiety, post-traumatic stress disorder and problems related to conduct and substance abuse.

6. Gold-standard longitudinal evidence by Cathy Widom and others has shown that child maltreatment is associated with lifelong risk for psychiatric disorders (Widom et al., 2007) and reduced economic productivity across multiple measures (Currie and Widom, 2010). Evidence from studies like King’s College London’s Environmental Risk (E-Risk) Longitudinal Twin Study, where researchers take into account genetic risk for psychopathology, suggest the association between maltreatment and psychiatric disorders is causal (Schaefer et al, in press). Cross-sectional studies of children and young people who have experienced maltreatment report significant changes in brain structure and function (McCrory, Gerin &
The development of psychopathology as a result of ACEs may in part arise because children need to adapt to survive in neglectful, chaotic or violent home environments. Such adaptations may be helpful in the short term, but in the long term increase vulnerability to later mental health problems. The theory of Latent Vulnerability articulates this broad position (McCrory and Viding, 2015) and follows from evidence that early adversity alters how children function in a range of ways – both psychologically and in terms of neurocognitive functioning (Danese and McEwen, 2012; McCrory, Gerin & Viding, 2017). For example, children growing up in homes characterized by physical abuse or domestic violence can become hypervigilant to threat cues, even at a subliminal level of processing (McCrory et al., 2013). This may be useful in the short term (when trying to survive in a violent home), but in more normal environments can lead to misinterpretation of facial expressions increasing the likelihood of interpersonal conflict. This in turn may make it more difficult to cultivate and sustain a supportive social network of relationships with peers and adults. We know that poorer social support is associated with increased risk of future mental health problems. Recent findings suggest that latent vulnerability may also be reflected in altered processing of the reward system and autobiographical memory system following maltreatment (McCrory, Gerin & Viding, 2017; McCrory, Puetz et al. 2017).

Victimised children also often show cognitive impairment. Longitudinal prospective research has shown that this is likely a risk factor for victimisation rather than a consequence of it (Danese et al, 2017). Nevertheless, the cognitive impairment negatively may affect engagement of children in education and complicates treatment (Nanni et al, 2012).

In terms of physical outcomes, there is a well-established association between childhood maltreatment and high levels of inflammatory biomarkers in the blood, which are known to contribute to the risk of cardiovascular disease and type 2 diabetes (Danese et al., 2007). Furthermore, there is an association between childhood maltreatment and obesity - a meta-analysis has shown how maltreated children become more overweight adults compared to non-maltreated children (Danese & Tan, 2014). The knowledge about other physical health outcomes in maltreated children is growing as more research focuses on the issue.

Because maltreated children often also experience other types of adversity, it can be difficult to isolate the effect of one type of adversity versus another. The most common solution to this complexity is to measure cumulative exposure to adversity – how many of these types of adversity these children have experienced (Felitti et al., 1998; Anda et al, 2005).

With regards to specific experiences and their impacts, the evidence suggests all types of adverse experience have general negative effects, qualitative differences across adversity types are limited (Vachon et al., 2015), and the main effect is a cumulative one. This suggests there is no specific effect of one type of adversity that should be prioritised or prevented in isolation. Prototype prevention strategies should therefore address several issues at the...
same time, rather than just one. For example, experiencing multiple forms of adversity of maltreatment – poly-victimisation – is common in the UK (Fisher et al., 2015).

12. Similar findings are emerging with regard to bullying of children by peers (Arseneault L, 2017).

The evidence base for interventions

13. While there is evidence that maltreatment significantly increases risk for a broad spectrum of negative outcomes, the evidence for interventions to offset that risk is much less established (Landers et al. 2017). There are few randomised controlled trials (RCTs) and most of these have focussed on PTSD – only one of several outcomes of experiencing maltreatment. One issue is that experiencing childhood adversity or maltreatment is not a diagnosis. Victims may present with a broad range of difficulties which fall across a range of different domains, and such difficulties may not arise until many years later. Victims tend to have complex presentations with comorbid difficulties, alongside placement, educational and attachment issues. This may lead to this group being seen as too difficult and outside the priorities of a mental health system that has traditionally organised funding along more ‘pure’ psychiatric diagnostic lines (e.g. ADHD, Autism etc). Real integration of social care, education, mental health, and physical health agencies is needed to effectively support these children.

14. There is a need to develop a more holistic approach to assessment that considers multiple domains of child functioning, and also to actively engage children and young people in thinking about their care. Assessments should ensure that a child or young person’s mental health and emotional wellbeing is considered in the light of their current situation and past experiences, rather than solely focusing on the presenting symptoms.

15. There is a case for moving towards a more preventative model of care. Waiting for clinical disorder to emerge down the line fails many children and makes effective intervention much more difficult, as problems have become severe and intractable. Rather, being able to screen and identify those children who are most vulnerable (i.e. those with the highest level of latent vulnerability) and then offering a preventative intervention that can offset the risk would transform current approaches to help. Prof Eamon McCrory is currently leading a four-year study with the NSPCC to try to develop the components of a standardised risk tool to identify children most at risk. These components will be short, computerised tools that may become part of a future screening measure. Similarly, Dr Andrea Danese is leading a study funded by the NSPCC to identify early clinical predictors of psychiatric risk and psychosocial impairment in maltreated children.

16. Systematic research is required to develop and evaluate forms of preventative help for these vulnerable children. Such work would explore how best to offset the risk of future mental health problems by providing early help and support. It would need to take into account that these vulnerable children are likely to have a set of co-current risk factors including parental mental health problems, genetic vulnerability and often chronic histories of abuse. Such risk
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factors will, in a dose-dependent way, increase their risk of mental health issues.

17. In summary, treatment for children who experience maltreatment and adversity is very poor in two respects. First, current mental health provision fails to meet the complex needs of this group, who do not fit within a simple diagnostic framework, and need to be better characterised clinically. Second, we currently have no evidence-based approaches to measure or target latent vulnerability and so allow the provision of preventative help to promote resilience and reduce the risk of future mental health problems.

18. We are lacking good data on long-term outcomes, both for early years interventions and for later interventions (Howarth et al., 2016) as follow-up periods tend to be very short. Long-term follow-up is essential if we are to assess whether improvements are stable (for those who are treated for presenting problems, such as post-traumatic stress disorder symptoms, depression and anxiety) or whether there is a reduction in emerging psychopathology (for those presenting with latent vulnerability). In relation to the former group, it is likely that standard treatment approaches will not be as effective as with children without a maltreatment history (Nanni et al., 2012).

Policy and evidence

19. Historically, there has been a ‘flavour of the month’ approach in both local and national policy in this area. There may be a sudden move towards attachment-based interventions or ‘neuroscience-informed’ interventions, without actually basing those on solid RCT evidence (Landers et al. 2017). The current challenge is not to ensure that practice reflects the evidence base, but generating a sufficient evidence base to inform practice. Studies are required which recruit affected children, offer RCT-delivered interventions, and then follow them up longitudinally. This kind of follow-up is incredibly difficult because typically children experiencing adversity are a very mobile group who may change social work area or foster placement. In spite of this, such follow-up studies are essential to determine the long-term benefit of any intervention.

20. There are several challenges involved in disseminating, accessing and using the latest evidence. In order to collate and interpret the complex evidence in this area it would be necessary to have shared expertise available that is not only clinical, but also includes epidemiology, statistics, and neuroscience. It could also be quite beneficial to develop a system of education for clinicians and policymakers. In other countries, transdisciplinary networks and events have been developed that bring together neuroscientists, epidemiologists and clinicians in the same place. Such an approach could allow the development of a shared language and a dialogue about findings and how they might be adopted clinically.

21. The NSPCC’s Science Advisory Board has done some work in this area, including a few events that aimed at translating the implications of science findings to clinicians. Such initiatives could be done more frequently, and reach many more people. Crucially, such collaborations
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should include a critical appraisal of the evidence that is passed on to clinicians.

22. The Harvard Centre for the Developing Child has been exemplary of this approach in the US, with no equivalent in the UK. A UK centre would need a broad remit to bring together evidence from social work practice to clinical psychology to neuroscience and paediatrics. By its nature, such a research area is not easily ‘owned’ by any single discipline. The approach therefore requires an overarching structure to bring practitioners, policy makers and researchers together.

Research oversight

23. After historic underfunding, there has been an increase in both interest and funding for research targeting child and adolescent mental health owing to the observed healthcare burden associated with ACEs. This has benefitted the study of childhood adversity.

24. There is no sense of a national strategy in this area, and it is not clear that there is a cogent way in which research priorities are being identified. It appears to be ad hoc and based on individual funding bodies and their own priorities.

25. There has been some dialogue between charities and between government bodies around oversight for actions in this area. However, there is at present no single authority coordinating and catalysing efforts. The NSPCC have provided some strategic vision, coordinating smaller charities and funders as well as undertaking a mapping exercise into funders for this area. The ESRC has started developing joint research calls with NSPCC. The Wellcome Trust and MRC have expressed interest in funding more work in this area.

26. There is currently no routine culture of evaluation and ongoing research of the evidence base. This is in part due to the difficulties in following-up children experiencing adversity over time.

27. Clear leadership is needed to build a framework around which observational studies, neuroscience studies and interventions in this area can be reviewed and integrated.

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References


