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March 2019

Trauma Issue

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Editorial

Guest Editor, Dr. Mark Lovell

The March 2019 edition of The Bridge focusses on traumatic experiences, outcomes and interventions. Trauma can occur in many forms from single exposure to a life threatening or fear inducing event, to sustained trauma ranging from neglect, other abuses, famine or war. All of which can present in clinical practice.

The adult research has always been more advanced in this area. However, there is now a greater focus occurring on these areas relating to children and young people. Rather than simply extrapolating adult research, the focus is now on what works for whom within childhood.

Certainly there has been an increased focus on the impact of adverse childhood experiences on longer term behavioural and mental health outcomes. There are clear patterns showing - the more exposure a child has to adversity, the worse the outcome.

Within this edition of The Bridge, there are research summaries from ACAMH's two journals JCPP and CAMH; by both the original authors and Jessica Edwards, ACAMH's science writer. It covers recommendations for refugee services responding to a refugee crisis, the impact of foster care on the outcomes of the children from Romanian Orphanages and a variety of articles relating to Post-traumatic Stress Disorder (PTSD). These PTSD articles are concerned with interventions, cost-effectiveness and the trajectories of symptomatology after a traumatic event.

Clinically these are all relevant with all Child and Adolescent Mental Health teams coming into contact with children that have been exposed to trauma in a wide variety of ways.

I hope that you enjoy reading The Bridge and consider putting some of the evidence into practice in line with guidance.

Dr Mark Lovell
Acting Editor

Research highlights in this edition are prepared by Dr. Jessica K Edwards. Jessica is a freelance editor and science writer, and started writing for 'The Bridge' in December 2017.

Eye movement desensitization and reprocessing improves PTSD symptoms in children

By Dr. Jessica K Edwards

Practice guidelines for childhood post-traumatic stress disorder (PTSD) recommend trauma-focused psychological therapies as the first-line treatment. The primary approach is trauma-focused cognitive behavioural therapies, which have a large evidence base.

Another approach is a brief, trauma-focused treatment based on eye movement desensitisation and reprocessing (EMDR). Here, the patient visualises a disturbing image from the trauma in their memory while engaging in sets of saccadic eye movements (looking side to side).[1] While this approach is recommended in the 2005 NICE guidelines[2] for use in adults, there is limited evidence for its efficacy in youths. Now, researchers have conducted a single-blind, multi-centre, randomised trial involving 103 youths aged 8-18 years allocated to one of three study arms: EMDR, cognitive behaviour writing therapy (CBWT) or wait-list (WT). The WL participants were assigned to one of the other two groups after a 6-week delay. EMDR and CBWT comprised of up to six sessions lasting 45 minutes each. Both treatments were well tolerated, and intention-to-treat analyses yielded large effect sizes for the primary outcomes at post-treatment, relative to WL.

Overall, 92.5% EMDR and 90.2% CBWT participants no longer met the criteria for PTSD, compared to 52.9% WL participants. This improvement was maintained at the 3-month and 12-month post-treatment follow ups. The researchers thus consider that a brief trauma treatment for youths with PTSD that requires minimal parental involvement and no training in coping skills can be highly effective.

Referring to:

De Roos, C., van der Oord, S., Zijlstra, B., Lucassen, S., Perrin, S., Emmelkamp, P. & de Jongh, A. (2017), Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy and wait-list in pediatric post-traumatic stress disorder following single-incident trauma: a multicentre randomized clinical trial. J. Child. Pscyhol. Psychiatr. 58: 1219-1228. doi: 10.1111/jcpp.12768.

Further reading:

[1] Shapiro, F. (2001), Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures, 2nd ed. New York: Guildford Press.

[2] NICE (2005), Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. NICE clinical guideline 26. Available from http://guidance.nice.org.uk/CG26 [NICE guideline].

Early cognitive therapy for traumatised young people works and is also cost-effective

By James Shearer

James Shearer is a research health economist at the Institute of Psychiatry, Psychology and Neuroscience, Kings College London. His interests are the economics of mental health treatments for children and adolescents and using economic modelling to measure wider impacts on families, and the long term impacts on education and employment.

This article is a summary of the paper published in JCPP - Shearer, J., Papanikolaou, N., Meiser Stedman, R., McKinnon, A., Smith, P., Dixon, C., Byford, S. (2018). Cost-effectiveness of cognitive therapy as an early intervention for post-traumatic stress disorder in children and adolescents: a trial based evaluation and model. Journal of Child Psychology and Psychiatry, 59, 773-780. doi: 10.1111/jcpp.12851

More than half of children and adolescents will experience traumatic events like vehicle accidents, house fires, or violence. However, brief counselling for young people in the immediate aftermath of an acute traumatic event has not be shown to be any more effective than not intervening and allowing natural recovery to take its course. Nevertheless, around 16% will go on to develop post-traumatic stress disorder (PTSD), a severe mental health condition with distressing and serious long-term symptoms such as intrusive memories, nightmares, problems concentrating and hypervigilance.

Untreated PTSD in early life is associated with other mental health problems, such as anxiety, depression and behavioural issues, and it has measurable economic consequences. These can include greater demand on NHS services, reduced quality of life for children and their parents, and problems in education leading to poorer employment and educational outcomes in later life.

In our clinical trial (published in the Journal of Child Psychology and Psychiatry last year), we evaluated a different approach to early intervention for youth exposed to trauma. Rather than attempting to intervene in the first few days or weeks, we waited until at least two months had passed to work with children and adolescents with significant PTSD symptoms, as a number of young people will experience natural recovery in the first weeks following a trauma.

Young people aged between 8 and 17 years who had not recovered by the two-month point were welcomed into the trial and were randomised to receive cognitive therapy for PTSD or a 10-week waiting list for the same intervention. Cognitive therapy for PTSD involved 6-10 individual sessions focused on supporting children and adolescents to process their trauma. This therapy primarily involves helping them to understand their PTSD symptoms and why they have occurred, develop a coherent account of what occurred in the trauma, update their understanding of what happened (especially the most threatening or distressing aspects of what happened) and address behaviours that may be helping to maintain their symptoms.

In addition to collecting information on PTSD symptoms and other psychological outcomes, we also gathered information about any health, education and social care services used by the children during the study. We interviewed parents using a questionnaire specifically designed to collect this information, called the Child and Adolescent Service Use Schedule (CA-SUS).

The CA-SUS asks about their child's attendance at different types of school classes, absences from school or work, hospital-based treatments, A&E attendances, medications and any contacts with a range of community-based health services like GPs and CAMHS workers. Our health economists then costed all of the services used by multiplying the number and duration of contacts by an appropriate unit cost.

The cost of the cognitive therapy was based on the number of contact hours multiplied by the hourly salary rate for a clinical psychologist Band 8a, factoring in overheads and non-contact time such as note writing, supervision, meetings etc. Overall, the children in the treatment group had an average of 636 minutes of contact time over 8 sessions, resulting in a value for the program of £1,463 per child, on average. We added this to the cost of the other services these children received and the total cost for the children who received cognitive therapy was £1,691 compared to £351 for the children who did not receive the therapy.

The next step in an economic evaluation is to look at the effects. In the UK, the main measure of effect used in economic evaluations is quality-adjusted life years (QALYs). QALYs weight survival time to reflect better or worse quality of life. For example, a year lived in perfect health equals 1 QALY but a year spent in less than perfect health is worth less depending on the severity of health problems. The lower the weight the worse the quality of life.

The children were not directly asked about their quality of life, instead we were able to estimate it from a clinical measure – the parent-completed Strengths and Difficulties Questionnaire (SDQ) – a widely used measure of mental health difficulties in young people. We used an equation which converted the SDQ score into a score on the Child Health Utility index (CHU-9D), a measure capable of generating QALYs. After 11 weeks, the children who received cognitive therapy had slightly more QALYs than those who did not.

Finally, we built a mathematical model, called a decision model, to forecast what would happen to the children up to 3 years after the study in terms of both their QALYs and costs. This was necessary because most of the benefits from treating PTSD will happen after the study has ended. The final result was that early cognitive therapy was estimated to be highly cost-effective compared to the comparison group after three years, costing £2,205 for every additional QALY gained which is well below the National Institute for Health and Care Excellence (NICE) guidance of £20,000 to £30,000 per QALY for new therapies to be accepted as good value for money in the NHS.

Economic data can be very influential and this study has already been used to inform the development of NICE guidance in PTSD. The effort made to collect detailed service use and quality of life data has really paid off and we encourage future studies to add these types of measures. The economic modelling, though complicated, was also invaluable in helping to demonstrate the longer-term benefits of a successful but intensive, and therefore costly, therapy.

Key points:

What this evidence suggests is that early PTSD is worth taking seriously and treating. These sorts of early reactions (i.e. 2-6 months post-trauma) are not just transient distress, and we know that treatment like cognitive therapy for PTSD can lead to improvement in quality of life in a way that is cost-effective. It may help parents, hospitals, schools and colleges to know that effective and cost-effective interventions are available to help children and young people, and consider how they might help them to access this kind of therapy. Future research might also help us to understand what is cost effective for treating other forms of PTSD in children and young people, e.g. following multiple trauma exposure. For now, however, the evidence suggests that investing in supporting mental health professionals to deliver psychological therapies such as cognitive therapy for PTSD is worth it.

Foster care promotes adaptive functioning in early adolescence among children who experienced severe, early deprivation

By Dr. Kathryn L. Humphreys

Dr. Humphreys is an Assistant Professor in the Department of Psychology and Human Development at Peabody College, Vanderbilt University. She directs the Vanderbilt Stress and Early Adversity Lab, where their work centres on understanding variation in children's early experiences, how early experience predicts child outcomes, and identifying targets in order to improve children's early lives.

This article is a summary of the paper published in JCPP - Humphreys, K. L., Miron, D., McLaughlin, K. A., Sheridan, M. A., Nelson, C. A., Fox, N. A., & Zeanah, C. H. (2018). Foster care promotes adaptive functioning in early adolescence among children who experienced severe, early deprivation. Journal of Child Psychology and Psychiatry, 59, 811-821. doi:10.1111/jcpp.12865

Experiences in our early life can have long-term consequences on development. Children who have experienced severe deprivation, in the form of institutional care (orphanages), are at greater risk to experience a range of social, emotional, and cognitive difficulties. In fact, much of the research tracing long-term consequences of early adversity have come from a deficit model (i.e., "what goes wrong for those with negative experiences"). Using a longitudinal study of children who spent their early lives in institutional care, my colleagues and I sought to examine what can go "right" despite adverse experiences, and identify features that promote resilient functioning following adversity.

For some context, in 2001 when the study began, there were a large number of children in institutional care in Romania. The Romanian government was unsure of the best practices for caring for these children, as there were genuine questions about the suitability of institutional care. After all, children in institutional care were typically having their instrumental care needs met (e.g., food, shelter, clothing). However, institutional care providers were unable to meet the social, emotional, and cognitive input needs of young children, and specialists in child development and mental health believed that family-based care was necessary for children to thrive. A randomised controlled trial, in which children were randomly assigned to usual care (typically remaining in institutional care for longer periods) or to a high-quality study-supported foster care, was designed. Only in the context of a randomised controlled trial can causality be supported to demonstrate whether foster care was an effective intervention for children who experienced early severe psychosocial deprivation.

Drs. Charles Nelson, Nathan Fox, and Charles Zeanah designed the Bucharest Early Intervention Project (BEIP), in which 136 children were selected, screened, and assigned to a foster care or care as usual group. Children were ages 6-31 months at baseline (average age of 22 months) and the foster care intervention was supported by the study until the children were age 54 months, as which point support for the foster care was provided by the Romanian child protection authorities. Children were assessed at multiple ages in the intervening years, and a comparison group of never institutionalised children were assessed at each age as well. At age 12 years, a thorough assessment including in laboratory cognitive tests, a session assessing physiological responses to stress, interviews with children and their caregivers, and self-report measures were completed.

Rather than take a deficit-oriented approach, we sought to characterise whether children were functioning "typically" in a number of domains. In most instances, we examined how the never institutionalised children were functioning, and if a child who was institutionalised functioned similarly to how these children were, they were considered "competent" in that domain. Further, in order to broadly assess whether children were functioning adaptively, we decided not to prioritise one single measurement of outcomes (e.g., presence or absence of a psychiatric disorder). Instead, we examined seven domains of functioning (i.e., mental health, physical health, substance use, risk-taking behaviour, family relations, peer relations, and academic performance), and for each domain, participants were given a score of 1 or 0. Individuals with competence in at least 6 of 7 domains were determined to be adaptively functioning in early adolescence. This threshold allowed for participants to have difficulty in one area and still be considered functioning well overall.

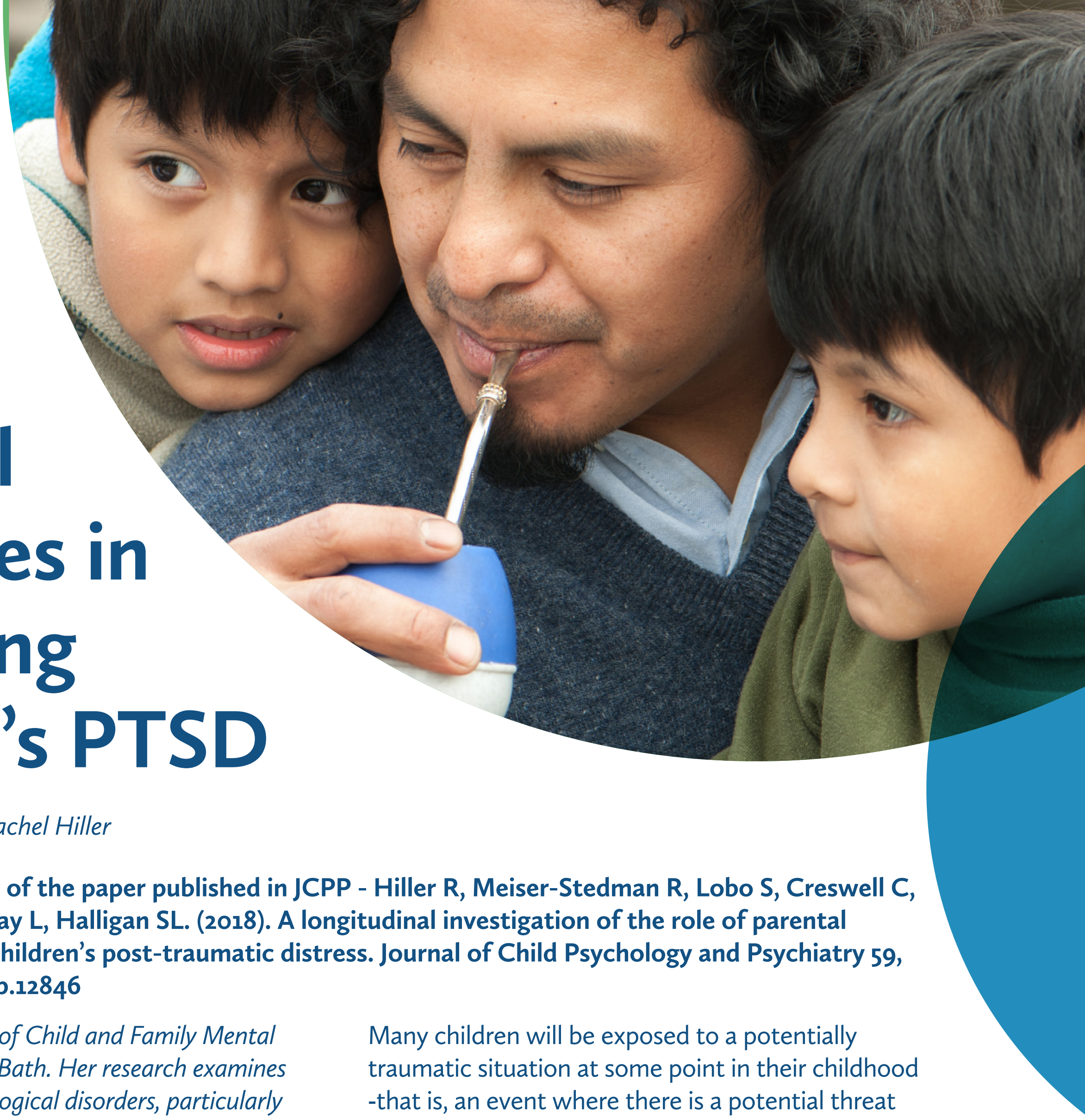
Among those children with a history of institutional care, 40 percent exhibited adaptive functioning. We examined whether our determination of competence was associated with other assessments not included in our adaptive functioning assessment. Children who were determined to be at or above the threshold had higher IQs and had more typical physiological stress response patterns when compared to those children below the cutoff. In addition, we found that girls, on average, were more likely to be competent than boys.

Perhaps the most important finding from these analyses were those that inform practices for children who experience adversity. We found that children randomised to the foster care intervention were over twice as likely to be competent in early adolescence. Further, those children placed earlier in life had a greater chance of being classified as competent. In fact, nearly 80 percent of children placed into a family prior to age 20 months were found to be competent at age 12 years, whereas the percent competent placed after that age was 46 percent.

We know that both individual differences and the environment affect child outcomes. The fact that 23 percent of the children randomised to the care as usual condition were determined competent, demonstrates that despite severe early adversity, some children still fare relatively well. Children vary in their susceptibility to both adversity and to environmental enrichment. At this point, we are unable to directly address plasticity of children. However, we can, as a society, prioritise institutions that support young children's development. This work indicates that, given the robust randomised controlled trial design, that family care for children is causal in promoting resilience after early adversity. Placing children early in life appears to be associated with the greatest chance for being competent across a number of domains in adolescence.

Key points:

- A subset of children who experienced severe early adversity are functioning in the typical range by adolescence.
- Placement into family-based care (as opposed to institutional care) promotes resilience to early adversity.
- Interventions that prioritize early placement (i.e., prior to age 20 months) are likely to be associated with the greatest gains.
- Policy-makers should consider finding permanent family placements for abandoned or orphaned children as early in life as possible to promote adaptive functioning in these children.



Parental responses in predicting children's PTSD

By Sarah L Halligan and Rachel Hiller

This article is a summary of the paper published in JCPP - Hiller R, Meiser-Stedman R, Lobo S, Creswell C, Fearon P, Ehlers A, Murray L, Halligan SL. (2018). A longitudinal investigation of the role of parental responses in predicting children's post-traumatic distress. Journal of Child Psychology and Psychiatry 59, 781-789. doi: 10.1111/jcpp.12846

Sarah Halligan is Professor of Child and Family Mental Health at the University of Bath. Her research examines the development of psychological disorders, particularly post-traumatic stress disorder (PTSD) and depression, with a focus on young people. In the PTSD field, Professor Halligan has studied the cognitive-behavioural, biological and social factors that contribute to disorder following trauma exposure, working with both national and international populations. She is particularly interested to learn how parents and others can support children and adolescents who are struggling with mental health problems, and to identify potential intervention targets.

Dr Rachel Hiller is a clinical psychologist and prize research fellow in the Department of Psychology, University of Bath. Her research explores the social and cognitive processes that link experiences of child trauma to poor mental health outcomes, and improving access to evidence-based trauma-focused mental health treatments. Her work is particularly focussed on young people exposed to trauma in the context of other adversities, including children and teens in care. She is currently funded by an ESRC Future Research Leader grant and MQ Data Science award.

Many children will be exposed to a potentially traumatic situation at some point in their childhood -that is, an event where there is a potential threat to life or of serious injury to the child, or to someone close to them. These events can range from common unintentional or accidental traumas, such as car accidents or serious sporting accidents, to deliberate harm, such as assault or maltreatment. Such trauma exposure can have a significant negative impact on a child's psychological wellbeing.

One important mental health problem that can arise following trauma exposure is post-traumatic stress disorder (PTSD). The symptoms of PTSD include intrusive memories of the event, such as via images, nightmares or "flashbacks"; avoiding reminders of the trauma; feeling agitated (including trouble sleeping, being easily startled); and having altered thoughts and feelings (including feelings of anger, low mood, and having a sense of being vulnerable / very unsafe). Such reactions are quite common in the weeks after a traumatic event and may be part of normal recovery for many children. In fact, there is good evidence that around half of the children who initially struggle with symptoms of PTSD following a trauma will get better within 3-6 months without any need for psychological intervention. However, after exposure to a one-off trauma between 10 and 20% of young people go on to develop chronic PTSD. Considering the large number of young people involved in accidental traumas each year (e.g. road traffic accidents), it is particularly important to understand the factors that promote or prevent natural recovery from occurring.

One factor that has been associated with better psychological recovery for individuals following trauma is the extent to which they feel supported by those around them. For children, parents or other caregivers are often the key source of such support. However, parents can feel particularly unsure about the best way to respond if their child is struggling to cope following trauma. For example, parents frequently have concerns about potential future threat or harm to their child, feel a need to provide extra care and protection, and try to limit child distress. They may try to keep their child away from situations that may remind them of their traumatic experience, which can limit opportunities for children to overcome their fears. In addition, parents are frequently managing their own distress relating to their child's trauma, even if they weren't themselves present at the time, which can make it harder to provide the best support.

In order to learn more about the potential role of parents following child trauma, we recruited 134 families presenting to hospital accident and emergency departments following child trauma exposure. We examined the ways in which parents responded in the first weeks following the trauma, using both questionnaires and direct observations of parents talking together with their child about the event. We then tested whether particular aspects of parental responses predicted children's symptoms of PTSD 6 months later. We controlled for children's initial symptom levels in our analyses, in order to identify factors that are specifically associated with children's recovery.

Our study found evidence that how parents respond in the aftermath of child trauma may be one important factor that influences children's psychological recovery. First, where parents were overly focused on threat and the child's vulnerability, including talking with their child about the trauma (e.g. "you could have died", "I don't think we'll ever get over this"), this predicted poorer recovery of child PTSD symptoms. Second, if parents supported an avoidant coping style in the child, for example by encouraging them to avoid places or activities that might remind them of the trauma, this also predicted higher levels of PTSD symptoms in the child 6 months later. We also found evidence that early parental responses influenced children's symptoms at least in part via children's own understanding of the trauma and ways of coping. Interestingly, general parenting approach (how warm or protective parents typically were) was not related to children's PTSD symptoms. Thus, parenting specifically in response to trauma characteristics seemed to be what particularly mattered.

Overall, our findings suggest that children may model their coping style following trauma partly based on how their parent responds, and that some parental responses, despite being a natural reaction to a highly distressing experience, may actually maintain a child's PTSD symptoms. This research is part of a growing body of evidence that parents could play an important role in supporting their child to overcome the potential psychological consequences of trauma exposure.

In future work, it will be important to examine how best we can help parents to provide effective support to their children following trauma. This will require a better understanding of the role of parent's own distress and coping in the process. Nonetheless, our research suggests that providing guidance to help parents mitigate their child's psychological distress following trauma could be beneficial. Working collaboratively with hospital emergency departments, general practitioners, and other services that provide care for children following trauma is one potential route to achieving this.

Key points:

- Providing parents with information on supporting their child post-trauma, including via front-line services such as GPs and emergency departments, could be one avenue for improving children's psychological recovery.
- Providing this information could also help support the parent(s) themselves, who are often affected by their child's trauma exposure, but can be unsure about the best way to support their child.
- Our research focused on one-off, mainly accidental traumas; we know much less about how parents respond to more serious child traumas (e.g., physical or sexual assaults).

Practitioner recommendations for PTSD: a 2018 update

By Dr Jessica Edwards

In 2018, Patrick Smith, Tim Dalgleish and Richard Meiser-Stedman compiled a Practitioner Review for the Journal of Child Psychology and Psychiatry on post-traumatic stress disorder (PTSD) and its treatment in children and adolescents. In their report, the researchers provide updates on the estimated rates of trauma exposure, and the incidence and course of PTSD in children. They also discuss the recent re-formulation to the diagnoses of PTSD in the DSM-5 and ICD-11, and how the changes are relevant to practitioners, and the recent advances in PTSD interventions. Smith et al., explain that exposure to trauma is relatively common in children, with more than half of young people being exposed to at least one potentially traumatic event by the end of adolescence.

Approximately 1 in 6 of these trauma-exposed children and adolescents are likely to develop persistent PTSD. There is no evidence that a universally delivered early intervention is harmful for trauma-exposed young people, but early interventions that are targeted to those who are symptomatic seem to be more promising in reducing symptoms. Trauma-focused treatments, including those based on cognitive behavioural therapy, prolonged exposure and cognitive therapy for PTSD are effective in treating PTSD, while eye movement desensitisation and reprocessing is an emerging new treatment showing some promising results for PTSD in young people. Going forward, Smith et al., explain that psychometric studies are needed to develop robust measures of PTSD symptoms and to diagnose PTSD according to the DSM-V and ICD-11 frameworks.

They hope that large-scale evaluations of treatment effectiveness in non-specialist community settings will be initiated, as well as studies that aim to adapt and evaluate treatments for very young children. Finally, they highlight that new methods of delivering effective treatments are urgently needed, given the limited service capacity of most healthcare systems.

Referring to:
Smith, P., Dalgleish, T. & Meiser-Stedman, R. (2018), Practitioner Review: Post-traumatic stress disorder and its treatment in children and adolescents. J. Child Psychol. Psychiatr. doi: 10.1111/jcpp.12983.

Latest evidence on mental health interventions and service response to refugee children

By Seyda Eruyar and Panos Vostanis

Seyda is a Lecturer at Necmettin Erbakan University in Turkey.

Panos is Professor of Child Mental Health at the University of Leicester, and founder of the World Awareness for Children in Trauma programme (WACIT: **www.wacit.org***).*

This article is a summary of the review paper published in CAMH: Eruyar, S., Huemer, J. & Vostanis, P. (2017). How should refugee services respond to the refugee crisis? Child and Adolescent Mental Health, 23, 303-312. doi:10.1111/camh.12252.

Seyda with ex-street child in Istanbul, Turkey.

The latest figures indicate that in 2016 65.5 million people had to leave their homes due to war and armed conflicts, of which around one third of are refugees who fled other countries to seek asylum. Children and young people up to 17 years constitute approximately half of the refugee population. In this review, we included 82 peer-reviewed studies on associated risk and protective factors, and practice-based studies that evaluated the effectiveness of interventions for refugee children in high- (HIC) and low/middle-income countries (LMIC). The review was structured according to the ecological framework, thus, risk/protective factors and associated interventions were presented in an individual, family, school, community and societal context.

Despite the variation in methodological approaches, there was consistency in the established high rates and comorbidity of mental health problems. Pre-migratory war trauma was more associated with the development of PTSD symptoms, while peri- and post-migratory factors were more linked to depression and anxiety presentations. Overall, older age, because of increased trauma exposure, and maladaptive coping strategies were established risk factors for the development of mental health problems. Limited, albeit promising evidence, indicates that adaptive coping strategies such as problem-solving, cognitive re-structuring and emotional regulation can protect refugee children in the face of ongoing adversity. The impact of pre- and post-migratory stressors on parental mental health was a frequent predictor of children's mental ill health, usually mediated by impaired parenting capacity. In contrast, parental support and family connectedness had a protective effect on children's well-being. Cultural and linguistic barriers to children's adaptation to the host country, stigma, discrimination, poor school attainment and exclusion were identified as post-migratory risk factors.

Compared to the volume of evidence on refugee children's mental health needs, and on the role of risk and protective factors, there was relatively limited evidence on the effectiveness of interventions in the literature. The majority of intervention studies were reported from HIC. These predominantly aimed at reprocessing children's experiences through trauma-focused cognitive-behavioural, narrative exposure, testimonial, interpersonal, eye movement desensitisation and reprocessing (EMDR), and creative therapies. These modalities largely aimed at attenuating PTSD symptoms by reconstructing children's past narratives, and resulting beliefs or emotions. Several studies reported improvement in PTSD symptoms and psychosocial functionality among refugee children, although the sustainability of therapy benefits have not been examined by follow up research. There were few examples of parenting or family interventions, with those reported focusing on past and current life experiences and adjustment strategies for the family unit as a whole, sometimes involving several refugee families. In contrast, many interventions were provided through schools. These were again predominantly trauma-focused and delivered in groups, but usually without actively involving the school or community.

The complexity and ongoing changes in refugee children's mental health needs support the importance of developing multi modal interventions that operate at all dynamically levels of the ecological framework. Despite their pragmatic and economic constraints, some interesting programmes were reported, which addressed refugee children's cultural adaptation, language difficulties, housing and access to services, in conjunction with individual and family interventions. A study in the US showed that such a multi modal programme that incorporated individual, group and family interventions led to improvement in different child mental health outcomes.

Intervention studies were surprisingly lacking in LMIC, despite the fact that the vast majority of refugees were hosted by them. In such studies, first-line responses were often delivered by paraprofessionals due to the lack of specialist resources. For example, CBT-focused Teaching Recovery Techniques, which led to reduction of PTSD and other emotional symptoms. Similarly, psychoeducation programmes for parents, which can be combined with other approaches such as nutrition support, can enhance parents' emotional responsiveness. Community-based interventions in LMIC were commonly implemented through groups and in refugee camps, with modalities including psychosocial activities, narrative exposure, interpersonal and creative therapies.

A number of conclusions can be drawn from this review for practice, service development and capacity-building. Trauma-focused and resilience-strengthening interventions should be combined, thus concurrently tackling both 'past' and 'here-and-now' related difficulties. Such interventions should be culturally adapted and co-produced with refugee children and families. In HIC, the priority should be to provide accessible and integrated care through joint protocols and care pathways by all agencies involved; and in combining individual, family and community interventions. Different levels of training should be available for interpreters, universal and specialist staff. In LMIC, the primary focus should be to enhance children's resilience by upskilling and maximising existing capacity of practitioners and community volunteers. Additional attention and guidelines across all systems should be developed for unaccompanied minors. These should encompass protection from sexual and labour exploitation, and quality of care.

Consequently, the authors propose a phased (stepped up) model of mental health care along six domains:

1) Ensuring physical and emotional safety
2) Nurturing and positive parenting skills by parents and other caregivers such as foster carers or residential staff
3) Resilience-building through schools and communities
4) Acquisition of therapeutic competencies by universal frontline practitioners
5) Evidence-based psychological interventions
6) Direct access to specialist mental health services for children who have not responded to the previous interventions levels

Key points:

- Policy: Establishment of joint protocols and care pathways.
- Service development and delivery: Multi modal approach to interventions at child, family, school and community level.
- Clinical practice: Integration of trauma-focused and resilience-building interventions.
- School and educational practice: School can act as hub in multi modal service model.
- Gaps and recommendations for future science: Evaluation of multi modal service model.

Trauma-focused group intervention is superior to usual care for young refugees

By Dr Jessica Edwards

Data from a randomised controlled trial show that trauma-focused group intervention delivered by trained social workers in addition to usual care (UC) is more effective in reducing post-traumatic stress symptoms (PTSS) in young refugees than UC alone. The trial, conducted by researchers at Ulm University, Germany, involved seven German child and adolescent welfare agencies, where participants were randomly assigned to receive either six sessions of the group intervention, known as "Mein Weg" (meaning "My Way" in English) (n=50; 94% male), or UC (n=49; 92% male).

Mein Weg — led by trained social workers — included education on PTSS, learning of appropriate coping skills and gradual exposure to overcome traumatic events and regain a sense of safety. As suggested by the pilot study data, intention-to-treat analyses showed that Mein Weg was superior to UC, with self-reported improvements in PTSS and depression symptoms. Caregiver-reported symptoms and self-reported dysfunctional post-traumatic cognitions, however, were not superior to UC. A major limitation to the trial was the use of questionnaires to evaluate outcomes and no clinical assessments were performed. In addition, the data do not indicate whether improvements after the intervention ends are maintained. Follow-up assessments must now be completed to determine the sustainability of the effects.

The researchers consider that this trial provides evidence for the feasibility and effectiveness of a trauma-focused group intervention for young refugees. Furthermore, they propose that following replication with independent clinical assessments, Mein Weg may be a valuable low-threshold component in a stepped care approach for young refugees.

Referring to:
Pfeiffer, E., Sachser, C., Rohlmann, F. & Goldbeck, L. (2018), Effectiveness of a trauma focused group intervention for young refugees: a randomized controlled trial. J. Child. Pscyhol. Psychiatr. 59: 1171-1179. doi: 10.1111/jcpp.12908.

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Adverse childhood experiences/ evidence on long-term effects of abuse versus how much is genetic

Professor Andrea Danese

Professor of Child & Adolescent Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience at King's College London. He is also Honorary Consultant Child and Adolescent Psychiatrist at the National and Specialist CAMHS Clinic for Trauma, Anxiety, and Depression at the South London & Maudsley NHS Foundation Trust.

Key Learning Points

- to appreciate the differences between prospective vs retrospective measures of childhood adversity
- to recognise the importance of pre-existing vulnerabilities (selection effects) in the long term associations between childhood adversity and health outcomes
- to acknowledge the need for new computational methods to inform individualised health risk prediction after childhood adversity.

Working with at-risk adolescents

Dr Troy Tranah

Consultant Clinical Psychologist, Head of Adolescent At-risk & Forensic Service, Head of Psychology and Psychotherapy for Child & Adolescent Mental Health Services, South London and Maudsley NHS Foundation Trust

Key Learning Points

- Understanding the wide range of presentations seen in an 'At-risk' service, including emerging borderline personality disorder, complex trauma, young offenders and transgender youth
- Understanding the different intervention pathways for these different but often overlapping groups
- Understanding the possible outcomes for these complex client groups.

How neuroscience is helping to motivate a preventative psychiatry approach: Latent vulnerability and the impact of childhood maltreatment

Professor Eamon McCrory

Eamon is Professor of Developmental Neuroscience and Psychopathology, UCL. His research focuses on early adversity and behavioural problems in childhood and he is particularly interested in studying affective processing and potential neural markers of resilience in the context of childhood maltreatment.

Key Learning Points

- Understanding how childhood maltreatment alters brain function
- Understanding the concept of Latent Vulnerability: How such changes in brain function may be adaptive in the short term, but have long term costs
- Understanding the importance of social functioning as a pathway to mental health vulnerability

Experiences of training and developing the MATCH approach

Dr Arnon Bentovim

Founding Director, Child and Family Training

Arnon is a Child and Family Psychiatrist, who with his wife Marianne, a Social work Consultant, Individual and Family Therapist founded the Child and Family Practice. They established the Child Care Consultation Service, and the Child Abuse Service at the Hospital and continue to provide assessments and consultations for the courts in complex child care cases.

Hope for Children and Families Intervention Resources

- Builds on the MATCH-ADTC paradigm -the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma and Conduct Problems, and the MAP Managing and Adapting Practice which focuses on a wide diversity of treatment targets and ages
- Integrates Common treatment elements and procedures from across the field of effective interventions into a co-ordinated framework
- Transforms the work of practioners from health, social care and education to meet the diverse complex, multiple mental health needs of children, young people and their families

Ethical issues arising in the provision of medical interventions for gender diverse children and adolescents

Dr Bernadette Wren

Consultant Clinical Psychologist, Gender Identity Development Service, The Tavistock and Portman NHS Foundation Trust. Bernadette used to work at Great Ormond Street Hospital with young people with serious problems around eating, and supported sick children and their families on the cardiac and renal units.

- Understanding that the care of gender diverse children and adolescents raises a number of questions that are as much ethical as medical or psychological, arising in new social territory at the interaction of emancipatory ideas about autonomy for sex/gender minorities, respect for the wishes of children and young people, and technological change.
- Gaining an appreciation of the kind of factual knowledge and scholarship that serve as an important context for moral thought and action, but understanding that an appeal to existing scholarship will not in itself settle the issue about when and whether to intervene in the lives and bodies of these children and young people.
- Understanding that ethical practice in such a service cannot be reduced to a single event - a treatment decision aimed at achieving the ethically ‘right’ outcome - but is to be found in the extended processes of assessment, exploration and the negotiation of consent within the UK medico-legal framework

ACAMH
The Association
for Child and Adolescent
Mental Health

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CONFERENCE

Helping young people in crisis: gender identity, personality problems, and complex trauma

Jack Tizard Memorial Lecture & National Conference

Friday 14 June / 09.30 – 16.30 / Royal College of Physicians London

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