



The Association
for Child and Adolescent
Mental Health

2021 New Issue 1

THE BRIDGE

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IS BACK!



New features
including:

Young Insights

Policy Reviews

Expert
Perspectives



Plus Research
Digests



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Welcome to the Bridge 2021

New Issue 1: Relaunch

I am delighted to relaunch the Bridge, ACAMH's long-running magazine. The Bridge is back with a new format and features that we hope will be accessible, interesting and useful for readers. Our articles will share the latest high-quality and clinically relevant child and adolescent mental health research, best practice and policy. We aim to inform readers' work with young people, to bridge the gap between expert evidence and current practice.

You'll recognise our Research Digests, summarising the world-class research recently published in ACAMH's journals – JCPP, JCPP *Advances* and CAMH – and occasionally other journals. We'll continue to publish Research Digests, which have been the backbone of the Bridge over recent years, keeping readers well-informed about scientific developments in our field.

New features

We're now adding Expert Perspectives, which provide broader discussions, written by knowledgeable researchers and clinicians, to give richer context. We're also including Young Insights, articles led by young people and parents, highlighting their experiences and priorities. These articles, and young people's and parents' contributions to other articles, will increase the relevance of what's learnt from the Bridge for the young people and families we work with. Additionally, the Bridge now includes child and adolescent mental health policy updates in our Policy Reviews.

Coming soon, readers can test what they've learnt from the Bridge in our online quizzes. We're also developing a section for ACAMH members to post Notices. Starting from next issue, we'll include Interviews with leaders whose work has influenced our understanding of child and adolescent mental health and our practice. Readers can submit questions for each interview, including our first interview with Dr Gordana Milavić.

Let us know what you think

I hope the Bridge will be an enjoyable read and provide a comprehensive understanding of key evidence on child and adolescent mental health. To inform further improvements, we'll be asking readers for feedback: I'm really keen to hear from you! I'd like the Bridge to be your magazine, covering what you want to read, and continuing to adapt to be as interesting, informative, and relevant as possible.

Thanks for reading on!



Dr Stephanie J Lewis is Clinical Lecturer in Child and Adolescent Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. Steph is keen to promote the translation of research and expert evidence into clinical practice to improve mental healthcare for young people, so is delighted and proud to be editor of the Bridge.

Genetics research informing mental health care

Anita Thapar discusses that genetic studies of mental health have revealed important insights about the influence of genes and the environment, and the nature of disorders. She explains how these insights could improve mental health care for young people and their families now and in the future.

Genetics research has advanced enormously and the NHS has stated its intent to harness the power of genetic discoveries to improve health. For child and adolescent mental health practitioners what are the implications for current practice, what is the future promise of genetics and what are its key limitations?

Can we use genetic tests to diagnose mental health problems now?

No, it is complex. Families need to understand that for the majority, mental health conditions are influenced by multiple, different genetic and environmental risks. There is not one gene that they can be tested for (unless a rare genetic syndrome like Tuberous Sclerosis is suspected).

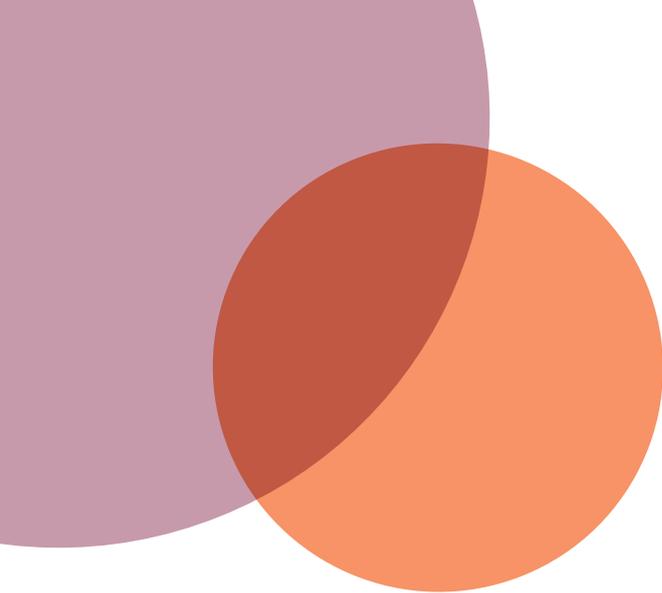
Mental health problems cluster in families in part due to inherited factors. The most highly heritable disorders are autism spectrum disorder (ASD), ADHD, schizophrenia and bipolar disorder. Depression and anxiety are much less heritable with a larger environmental contribution.

All of us share most of our DNA in common; research focuses on the DNA differences or genetic variants. Some gene variants are common, each with small effects; common gene variants are the major contributor to mental health problems. Other gene variants are rare with larger effect sizes. Rare, larger effect size variants have been found to be especially important for intellectual disability and autism and also contribute to schizophrenia, ADHD and Tourette's disorder. Future testing for rare, large effect size variants is a possibility (see later).



Professor Anita Thapar is Professor of Child and Adolescent Psychiatry at Cardiff University. She heads the academic Child & Adolescent Psychiatry section at the Division of Psychological Medicine and Clinical Neurosciences, and also directs the developmental disorders group within the MRC Centre for Neuropsychiatric Genetics and Genomics. Her research focuses on the origins, development and complications of child neurodevelopmental disorders and adolescent depression as well as gene-environment interplay. Anita is a child and adolescent psychiatrist. She remains a clinician as well as academic and also provides expertise for child and adolescent mental health policy development in Wales.

Photo credit: BigT images/Academy of Medical Science



Diagnoses are not defined by biology

Genetic risks associated with some diagnoses, such as ASD, ADHD and depression, also contribute to symptom levels in the healthy general population; they do not clearly demarcate diagnoses. While diagnoses can be helpful for selecting evidence-based interventions (e.g. we would not use antidepressants to treat ADHD), as practitioners we need to recognise they are a tool and not underpinned by biology.

Additionally, genetic risks are not specific to one diagnosis. For example, ASD risk genes overlap with those associated with ADHD and Tourette's disorder. This means that a child with ASD is more likely also to display ADHD or a mixed bag of neurodevelopmental difficulties. Genetic studies confirm what is well recognised by practitioners in real life, children do not present with a single clear-cut diagnosis.

The genetic overlaps also mean that practitioners are likely to observe a mix of different disorders in the same family. For example, one child may present with ADHD, his sibling with ASD, and other family members show learning or social/communication problems. There also is strong genetic overlap between all the different psychiatric disorders (e.g. schizophrenia and depression) as well as with neurodevelopmental disorders (e.g. ADHD, ASD).

These and other findings highlight that today's ADHD or ASD could become tomorrow's adolescent depression or bipolar disorder. Practitioners require the skills and training to recognise and manage a broad range of psychopathology beyond a single diagnosis. Policies and services around a single condition do not make sense scientifically.



These findings highlight that today's ADHD or ASD could become tomorrow's adolescent depression or bipolar disorder

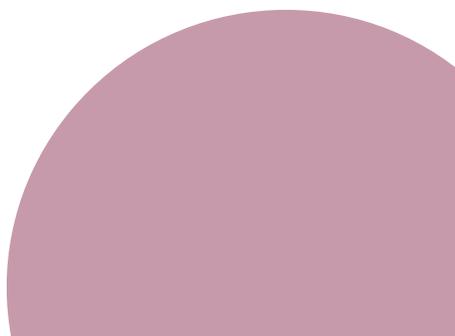
Anita Thapar

Cross-generational transmission: recognition and management

Genetics findings remind us about the importance of recognising cross-generational mental health and neurodevelopmental problems. This has implications on how well we link with primary care and adult services as effective intervention for parents may be crucial to improve family engagement with CAMHS, optimise the effects of the interventions we provide and improve offspring mental health.

Genetic liabilities and environmental risks work together

Genetics research has shown that genes and environment often are closely linked. Genetic liability (e.g. for ADHD) can lead to an increased risk of environmental stressors (e.g. parent-child hostility) that in turn lead to worse outcomes. Just because a disorder is genetically influenced, does not mean environment is irrelevant or that interventions necessarily will be pharmacological.



It is important to consider also the potential risks of having genetic risk information at hand

Anita Thapar

The future

If rare large effect genetic variants require medical action or have implications for treatment and future outcomes, genetic testing of these variants in those with ASD, ADHD, Tourette's disorder and schizophrenia may become routine. It is already in place for intellectual disability in the UK (and ASD in the United States).

For common small effect gene variants, scientists are investigating their combined effects (polygenic risk scores; PRS). At present PRS are too weakly predictive to have practical value. However, it is possible with larger studies in the future they become more strongly predictive of developing a disorder, likely outcomes and treatment response when utilised with other types of information (e.g. family history, clinical symptoms). For example, when we see an adolescent with depression whose parent has bipolar disorder, we likely become more vigilant about the possibility of emerging adolescent bipolar disorder but realise this is only a probability not a definite outcome. Bipolar PRS in the future could further help shape decisions around follow up.

With more and more discoveries, it is important to consider also the potential risks of having genetic risk information at hand. These include the complexity of genetics, interpreting test findings as well as concerns about potential harms and stigma. Thus, most agree that genetic counselling will be essential before testing is considered in the future. Another limitation is that PRS works best for a population similar to the one used for genetic discovery and at present that is mainly people of European ancestry.

As genetics becomes an integral part of the NHS, it is important for mental health practitioners to be prepared when families request information on testing.

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ACAMH Podcast: ADHD, autism, and the elevated risk of later depression, Anita Thapar



ACAMH The Bridge article: What does a CAMHS MDT need to know about the genetics of psychiatric disorder? Joanne Doherty and Olga Eyre



ACAMH lecture: Future challenges for the science of child psychology and psychiatry, Robert Plomin



Are ACE scores useful for identifying individuals at risk of health problems?

Clinics are increasingly screening for ACEs, but ACE scores may not tell us who will go on to develop poor health, explain Jessie R Baldwin and Andrea Danese.

One in two children in the UK are exposed to adverse childhood experiences (ACEs), such as abuse, neglect, or dysfunctional home environments.^{1,3} Because ACEs are associated with poor health outcomes in later life, public health advocates are interested in buffering the impact of ACEs through targeted health interventions.

To identify children and adults who may be at risk and benefit most from these interventions, several clinics and schools screen for ACEs. Children and adults with high ACE scores (generally 4+ ACEs) are thought to be at high risk for later health problems and may be offered interventions. But can a person's ACE score accurately predict whether they will have future health problems?

ACEs and population-level risk of health problems

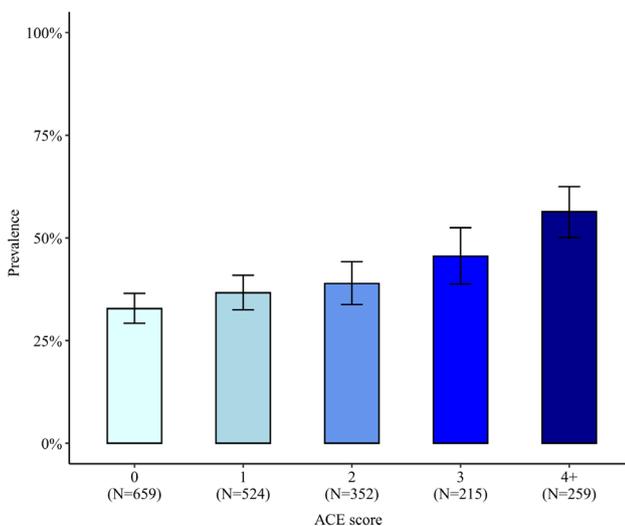
To answer this question, we studied two birth cohorts from the UK and New Zealand – the E-Risk Longitudinal Twin Study and the Dunedin Longitudinal Study.¹ ACEs were assessed in childhood through interviews and observations in both studies, and were also self-reported in adulthood in the Dunedin Study. Participants were then assessed for later mental and physical health problems – in late adolescence (age 18) in E-Risk or at midlife (age 45) in Dunedin.

We first examined whether ACE scores were associated with risk of health problems in the population. Like in the original ACE Study,⁴ we

found that groups of children with higher ACE scores had a greater risk of mental and physical health problems later in life.¹

For example, a larger proportion of children with 4+ ACEs had later mental health problems compared to children with fewer ACEs, as shown in Figure 1. In other words, as a group, children with 4+ ACEs had higher average risk of mental health problems than children with fewer ACEs (relative risk = 1.14 for each additional ACE; 95% confidence interval = 1.10-1.18).

Figure 1. Prevalence of mental health problems at age 18 in the E-Risk Study by ACE score. Adapted with permission from Baldwin et al. (2021).¹

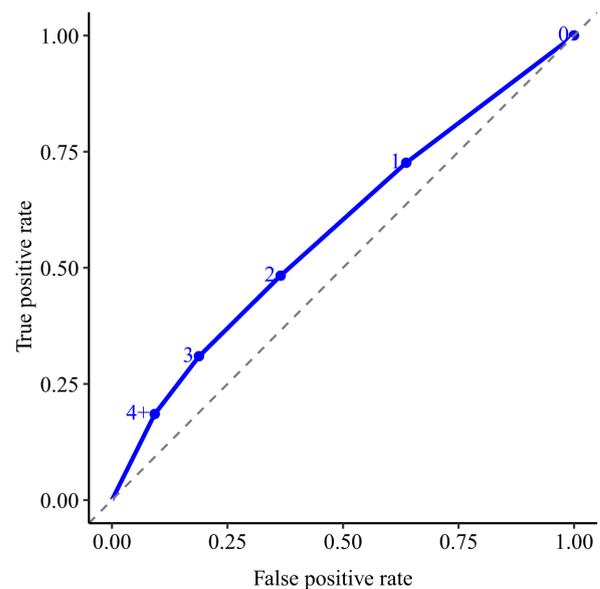


However, as also shown in Figure 1, not all children with 4+ ACEs had mental health problems – and some children with fewer or no ACEs had mental health problems. Because of these differences between individuals in each group with the same ACE score, it was unclear if ACE screening could accurately predict risk for individual children.

ACEs and individual-level risk of health problems

To test whether ACE scores could identify individuals at risk of health problems, we computed the Area Under the receiver operating characteristic Curve (AUC). The AUC shows whether the prediction of health problems based on each ACE score identifies more true positive results (e.g., the proportion of people with mental health problems who had 4+ ACEs; on the y axis in Figure 2) than false positive results (e.g., the proportion of people without mental health problems who had 4+ ACEs; on the x axis in Figure 2).

Figure 2. Accuracy of predicting mental health problems based on ACE scores in the E-Risk Study. Adapted with permission from Baldwin et al. (2021).¹



If ACE scores identify the same rates of true positives and false positives (the dashed diagonal line in Figure 2), then the prediction simply reflects chance with AUC = 0.5 – it’s like flipping a coin. If ACE scores identify more true positives than false positives, then the prediction is progressively better than chance, with increasing AUC (up to AUC = 1 showing perfect accuracy).

We found that the AUC for having a mental health problem was 0.58 (95% confidence interval = 0.56-0.61; Figure 2). This AUC represents a 58% probability (i.e., only 8% above chance) that a random child who developed a mental health problem had a higher ACE score than a random child who did not. In other words, the ACE score couldn’t accurately distinguish a child who developed a later mental health problem from a child who did not.

Predictive accuracy was generally poor across several physical and mental health outcomes in both cohorts.¹

Implications for ACE screening

These findings suggest that a person’s ACE score is not a good indicator of whether they will go on to develop health problems. Therefore, allocating health interventions based on ACE scores alone is a poor strategy: many people at risk of health problems would be missed because they didn’t have high ACE scores, while others with high ACE scores but low risk of developing health problems would be offered unnecessary interventions (with potential harms and costs).

Of course, ACE screening might be useful in other ways, such as identifying vulnerable children who need safeguarding – assuming that effective interventions could be provided.

Our findings caution against the deterministic use of traditional ACE scores for individual risk prediction and clinical decision making. However, future research should test whether ACE screening could be adapted to better identify individuals at risk of health problems, for example by focusing on the most predictive adversities⁵ or combining ACE scores with information about protective or vulnerability factors.⁶



Dr Jessie R Baldwin is a Sir Henry Wellcome post-doctoral fellow at University College London and visiting researcher at the Social, Genetic and Developmental Psychiatry Centre at the Institute of Psychiatry, Psychology and Neuroscience, King's College London. Her research focuses on understanding the relationships between childhood trauma and health.



Professor Andrea Danese is Professor of Child and Adolescent Psychiatry at the Institute of Psychiatry, Psychology and Neuroscience at King's College London. He leads the Stress and Development Lab, investigating childhood trauma and trauma-related psychopathology across the life-course. He is also Honorary Consultant Child and Adolescent Psychiatrist at the National and Specialist CAMHS Clinic for Trauma, Anxiety, and Depression at South London and Maudsley NHS Foundation Trust.

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- ¹ Baldwin JR et al (2021). Population vs individual prediction of poor health from results of adverse childhood experiences screening. *JAMA Pediatr*, 175, 385–393.
- ² Houtepen L et al (2018). Adverse childhood experiences in the children of the Avon Longitudinal Study of Parents and Children (ALSPAC). *Wellcome Open Res*, 3, 106.
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- ⁴ Felitti VJ et al (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*, 14, 245–258.
- ⁵ Turner HA, et al. (2020) Strengthening the predictive power of screening for adverse childhood experiences (ACEs) in younger and older children. *Child Abuse Negl*, 107, 104522.
- ⁶ Baldwin JR & Danese A (2021). Research, practice and policy implications of adverse childhood events - reply. *JAMA Pediatr*, 175, 867–868.

Related links

 [ACAMH Blog: Why it's time to ACE the way we measure the bad things that happen to children, R Lacey](#)

 [ACAMH Topic Guide: Trauma, A Danese & P Smith](#)

 [ACAMH Tag: Adverse childhood experiences](#)

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Complex PTSD in young people in care

Aishat Hamzat, Rachel M Hiller and Helen Minnis discuss what research tells us about the mechanisms underlying complex PTSD symptoms experienced by young people in care. They consider implications for treatment and broader support provided for these young people.

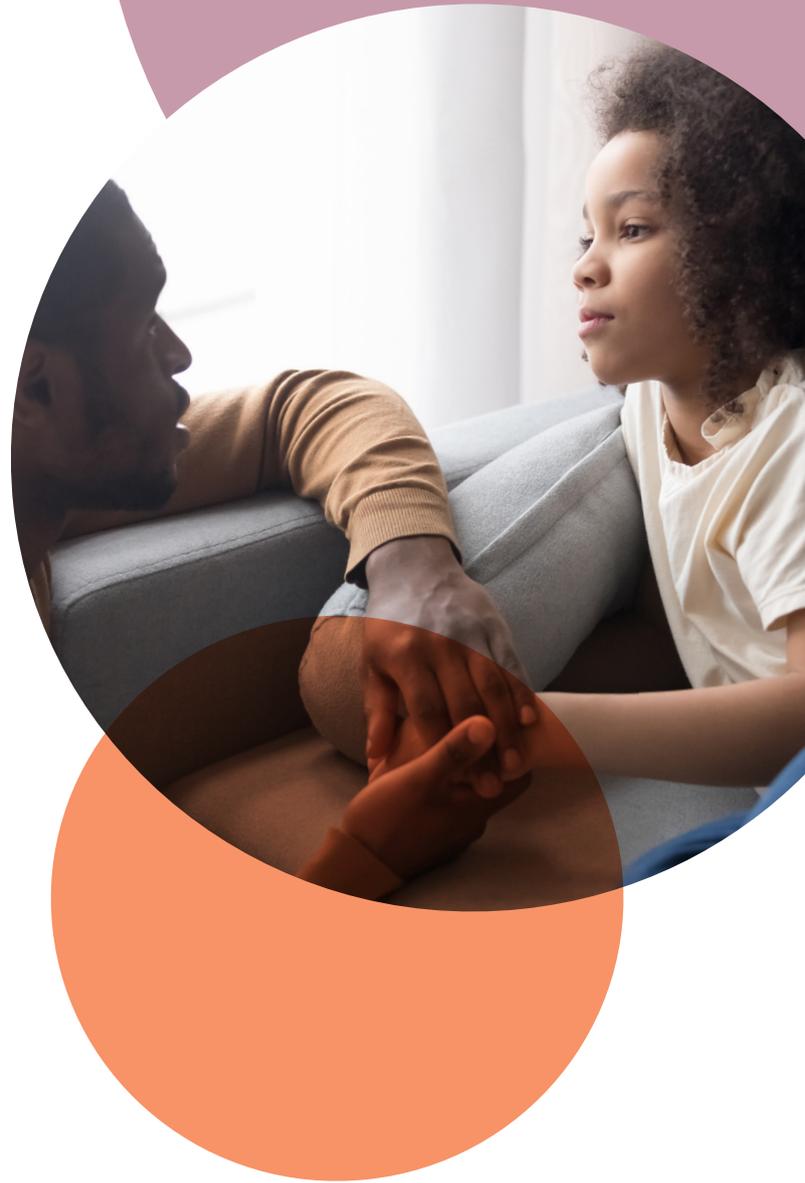
In March 2021 we joined CAMHS around the Campfire, the online journal club run by ACAMH and the Mental Elf, to discuss Rachel's recent paper on complex posttraumatic stress disorder (PTSD) in young people in care.¹ Briefly, this paper presented results of a longitudinal study exploring the role of key cognitive predictors of both 'standard' PTSD and complex PTSD symptoms. The sample included 120 10-18 year-olds living in care in England. The study found that our current models of PTSD were applicable to young people in care. Maladaptive cognitions (e.g., "I can't trust anyone" or "the world isn't safe"), cognitive coping (e.g., avoiding thinking about what happened), and memory qualities (e.g., memories being muddled or confused) were all associated with PTSD symptoms and complex features. Maladaptive cognitions were particularly important. This suggests that targeting these mechanisms in intervention would be useful for young people with complex PTSD symptoms. In this article we reflect on some of the important points raised in the Campfire discussion about this research.

Are PTSD and complex PTSD different?

PTSD is a trauma-specific mental health difficulty. A young person who has experienced trauma (whether that might be called maltreatment, complex trauma, developmental trauma, or any other trauma exposure) is at risk of developing PTSD. According to the World Health Organisation's diagnostic classification system (ICD-11), PTSD includes three symptom clusters: re-experiencing the trauma, avoiding reminders of the trauma and hyper-arousal. Young people with PTSD commonly also have other mental health problems, such as depression or anxiety. We know that rates of PTSD are very high in care-experienced young people. Complex PTSD is a new diagnosis in the ICD-11, but has not been included in the American Psychiatric Association's

diagnostic classification system (DSM-5). Crucially, to meet criteria for complex PTSD, the young person must have PTSD as well as additional complex features of difficulties with: relationships, emotion dysregulation and negative self-concept (e.g., "I'm not worth anything").

Rachel's work indicates that the same processes that drive PTSD, also drive complex PTSD. This suggests we may not need to develop completely new treatments for complex PTSD. We already have interventions that target these processes – called trauma-focused cognitive behaviour therapies (tf-CBT), the NICE-recommended first-line treatment for PTSD.² There is growing research supporting this by showing that tf-CBT is an effective treatment for those with complex presentations.³ It's possible that young people with complex presentations may benefit from more sessions to allow a more in-depth focus on certain aspects of treatment.



Getting young people in care the right treatment

It's important that young people in care get the right treatment to address their needs. We know that even our best evidenced treatments do not work 100% of the time for 100% of young people, but they should be the starting point to giving young people the best chance at overcoming their mental health difficulty.

As with any treatment, it is also important that the young person receives appropriate psychoeducation, not just about PTSD, but also about the treatment. People with PTSD often want to avoid thinking about what they have been through, which means they might struggle to engage in earlier sessions or not turn up to some sessions. In the psychoeducation component of tf-CBT it is important that avoidance is openly discussed. Similarly, it can be useful for practitioners to reflect on whether they may inadvertently encourage avoidance by delaying starting parts of treatment that are harder, such as memory work.

We also acknowledge the barriers that often exist in services that might mean practitioners find it difficult to deliver tf-CBT. It might be that they are not able to provide the required 12-20 sessions, or that they do not have training and supervision available to them. But there also seems to be a pervasive belief that tf-CBT is not appropriate for young people exposed to complex trauma, like abuse. This belief is not supported by the evidence or the most recent NICE review for PTSD, and is also challenged by mechanism research. Understanding how we can address service-level and individual-level barriers remains an important area of research, so practitioners and services can be encouraged and supported to deliver evidence-based treatments, such as tf-CBT.

Listening to young people in care

Another important issue is the need for researchers and practitioners to listen to, and genuinely hear, the views of young people in care. Young people in care are young people first – they are as different to each other as any group of young people. Some young people we have spoken to had gone for mental health support, only to feel let down by not receiving support that helped them. Some felt so let down that they decided never to engage with mental health services again. Aishat, a young person with care experience, spoke from her own experience about feeling patronised and let down by her initial contact with services. She felt that her

initial experience seeking professional help was met with a lack of validation of the mental preparation it had taken her to even ask for help. Aishat felt that professionals often overrode her experience with their own assumptions. She talked about often feeling rushed and not being given the opportunity to talk about her experiences, and that she had sometimes felt that her memories were being invalidated or judged as biased or inaccurate. Aishat believes it is important to recognise the time it may take for a young person to truly scrutinise their trauma and accept its effects; bombarding them with information they're not ready to receive will only hinder rather than help the process. Because of the trauma experienced by young people in care, it seems we sometimes just accept that mental health difficulties are inevitable or unchangeable. We all agree that it is vital that we challenge this assumption, especially because young people might then internalise this message – e.g., “I'm too damaged to be helped”, “no one can help me”, “what I went through was so awful that not even adults want to hear me talk about it”.

Related to this, we also discussed how important it is that professionals work alongside young people and consider their individual needs within their treatment plan. While young people may not always be able to label the psychological effects of their trauma, they are the expert in their own experience. We know that many young people in care have been let down by adults in their life (before care and in care) and might struggle with trust and relationships (this can be particularly true for those with PTSD). Building rapport is therefore very important.

Future work

There is much research to be done in the field of young people in care. Compared to research on the general population of young people, we are still far behind in what we know about the mental health needs of these groups. We all discussed the importance of moving this field forward with more large-scale projects, so that we can more strongly advocate for evidence-informed support for young people in care and care-leavers.

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² NICE (2018). *Post-traumatic stress disorder: NICE guideline [NG116]*.

³ Sachser et al (2017). *Complex PTSD as proposed for ICD-11: validation of a new disorder in children and adolescents and their response to trauma- focused cognitive behavioral therapy*. *J Child Psychol Psychiatry*, 58, 160–168.



ACAMH CAMHS around the Camp-fire: Webinar discussion of this topic



Scotland's Independent Care Review: The promise



Child Trauma Recovery: Evidence-based information for parents and carers

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Aishat Hamzat is a care leaver, student and volunteer campaigns advisor for the National Youth Advocacy Service.



Dr Rachel M Hiller is a Reader in Child and Adolescent Clinical Psychology in the Department of Psychology, University of Bath. Her research examines cognitive-behavioural processes that link the experience of child trauma or maltreatment to psychological outcomes, with a focus on (complex) posttraumatic stress disorder. Her work is also particularly focused on improving the mental health outcomes of young people in the child welfare system, including testing new cross-sector interventions for PTSD and improving access to existing evidence-based treatments.



Professor Helen Minnis is Professor of Child and Adolescent Psychiatry at the University of Glasgow. She has had a longstanding clinical and research focus on the psychiatric problems of abused and neglected children, including attachment disorder. Currently her focus is on intervention research, including a randomised controlled trial of an infant mental health service for young children in foster care and a randomised controlled trial of Dyadic Developmental Psychotherapy for primary school-aged children in adoptive or foster placements.

Conflating risk and mental illness

In this thoughtful article, a young person, Anna, reflects on her experience of risk being conflated with mental illness in child and adolescent mental health services (CAMHS), highlighting crucial lessons for clinicians, commissioners, and policy makers.

I have often felt that physical risk (like self-harm or suicide attempts) is interpreted as synonymous with mental illness by clinicians, and is (mis)used as a measure of severity. If young people are not physically hurting themselves in some way, it can often feel as though our mental health concerns are not seen as worthy of treatment. Perhaps this is because people still don't value mental health the same as physical health, so a mental illness alone doesn't seem serious enough to warrant treatment. Or because physical injuries are just easier to measure and believe. Whatever the reason, it can seem like young people need to self-harm and/or attempt suicide to be considered mentally ill 'enough' to get support from stretched services. While self-harm and suicide attempts are very rarely only, or even mainly, done 'for attention', this can be an unexpected benefit and sometimes the only way to get help.

My experience

There were many times when I have tried to get help for feeling depressed, but was only offered it after acting on suicidal feelings. The first time I was referred to CAMHS, I was told I didn't qualify for treatment, despite feeling depressed for several years and planning to kill myself. Several months later, after a suicide attempt, I was referred to CAMHS again and this time I was accepted. I don't think anything about my feelings or situation had changed, and I can't imagine I scored any higher on any depression measure the second time. Nothing seemed different except I had gone one step further.



Another time, I was told by mental health staff in A&E to "come back again if you start feeling worse" after explaining I was feeling really low and was planning to hang myself. Can it get much worse? I felt I was left with the choice to get better by myself, or kill myself. And I had already failed at getting better alone. It's hard to prevent suicide when people only qualify for help after trying to complete it. Many of those people won't be lucky enough to be unsuccessful.

This isn't only an issue with suicide, or in the beginning stages of accessing treatment. I also noticed it with self-harm once I was accepted to CAMHS. My self-harm seemed to be regarded as a measure of mental illness severity, and most sessions started with a discussion of how I'd hurt myself that week. Because I hadn't cut as deep as some of my therapists' previous patients, it seemed they thought my mental illness wasn't that bad. If I had done less, or more but shallower, compared to the previous week, this seemed to be regarded as a sign I was getting better. Teachers seemed to share this view, and told me "you must feel better than before because you haven't cut yourself". So I couldn't win. If I stopped self-harming, I was perceived to be better and didn't need any support; but if I continued, I was continuing down the damaging

It's so important to not become desensitised to suffering that isn't physical

Anna

spiral and the support was perceived to not be working, leading some teachers and clinicians to suggest it be taken away.

I think I only began to make real, and lasting, progress when a new therapist took me seriously all the time, and provided depression treatment even when I wasn't self-harming. In cognitive behavioural therapy, I had time to really think about why I was depressed and how to cope. I had this time because I had already stopped self-harming, ironically, because I didn't feel I needed to as I had committed to killing myself after my GCSEs. But luckily, the therapy actually broke through and I changed my mind. Unfortunately, I reached that point after several years of depression, as well as self-harm and suicide attempts.

Going forward

To provide useful support, it's important for clinicians to take young people seriously even when they are not physically at risk, and appreciate that mental illness still drastically affects quality of life. Children shouldn't have to self-harm or attempt suicide to prove that. Additionally, it's more helpful to focus conversations about self-harm on the reasons behind and feelings before and after it, rather than about exactly what has been done. This allows people to understand how they are feeling and how to manage it, instead of just putting plasters on the situation by offering self-harm alternatives that just don't cut it. If you can't offer treatment because of limited resources, it can be helpful to acknowledge to the young person that their mental illness is an important problem, and that it isn't their fault that poorly funded CAMHS can't provide the support they need. This emphasises that they don't need to change their behaviour or put themselves at risk to be worthy of help.

I know it can be really difficult, particularly in a system that isn't built to be preventative or funded enough to treat everyone, but it's so important to not become desensitised to suffering that isn't physical. I think that if I had felt cared about and received treatment earlier, it wouldn't have escalated so far and I wouldn't have so many years of my adolescence tainted by mental illness, self-harm, suicide attempts and trips to A&E, not to mention fewer physical scars to deal with for the rest of my life. I can't get my childhood back, but we can still prevent others from losing so much of theirs.

This moving account highlights the importance of building services that are adequately resourced to recognise mental illness and provide timely evidence-based treatment for all affected young people. Research demonstrates that many interventions for young people with mental illness are both clinically effective and cost-effective,¹ yet the majority of affected young people do not receive this treatment.² Therefore, there's a strong ethical and economic case to strengthen CAMHS, so that fewer young people have the same experience as Anna, and more receive effective treatment when it's needed.

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¹ Khan L et al (2015). *Investing in children's mental health: a review of evidence on the costs and benefits of increased service provision.* Centre for Mental Health.

² Mandalia D et al (2020). *Mental health of children and young people in England, 2017: professional services, informal support, and education.* NHS Digital.

Related links



[ACAMH Blog: We neglect children's mental health at our peril, S Scott](#)



[ACAMH Topic Guide: CAMHS \(Child and Adolescent Mental Health Services\)](#)



[ACAMH Topic Guide: Self-harm and suicide, R Sedgwick et al](#)

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Do autistic girls have better communication and interaction skills than autistic boys?



Dr Jessica Edwards

Research Digests in this issue were prepared by Dr Jessica K Edwards. Jessica is a freelance editor and science writer, and has been writing for the Bridge since December 2017.

There is ongoing debate as to whether autism spectrum disorder (ASD) differentially affects males and females. Several meta-analyses have found little difference between males and females with ASD in terms of social communication and interaction skills.¹ However, such analyses have often relied on diagnostic instruments such as the Autism Diagnostic Observation Schedule, Second Edition (ADOS-2)² that may not be sensitive to how autism presents in females.^{3,3} What's more, many have been based on global ('broad construct') scores,⁴⁻⁶ that reflect overall social communication and interaction skills, which could miss subtler differences in specific domains ('narrow constructs').

To overcome these limitations, Henry Wood-Downie, Bonnie Wong and colleagues at the University of Southampton conducted a meta-analysis to

investigate sex/gender differences across autistic and non-autistic children, adolescents, and adults in narrow constructs of social communication and interaction (e.g., peer relationships) that were not measured using diagnostic instruments. Across 16 studies (2,730 participants), they found a significant difference between autistic females and males in terms of their social interaction and communication skills. Specifically, they found evidence of more advanced social skills in autistic females than males that mirror sex/gender differences in non-autistic individuals.

“Our findings suggest that there are important differences between autistic males and females in terms of their social presentation, which are likely not captured by current diagnostic instruments”, explains Wood-Downie. “This issue might contribute to the under reporting and late recognition of autism in females, thereby delaying access to support”.

The researchers explain that education and health professionals might be less likely to recognise and refer autistic females for assessment and support due to differences in their social presentation, compared to males. The researchers explain that affected females might not exhibit stereotypical features associated with autism; for example, they might appear to be part of social groups in the playground.

“We were interested to find that non-autistic females also had more advanced social skills than non-autistic males”, describes Wong. “With this in mind, we therefore consider it important that practitioners account for normative sex/gender differences, such as comparing potentially autistic females to non-autistic females, where differences may be more apparent”.



ACAMH CAMHS around the Campfire: Trajectories of autistic social traits in CYP and disordered eating at age 14 years



ACAMH Podcast for parents: How autism presents differently in girls, A Ozsivadjan & M Murin



ACAMH Podcast: Transforming the lives of young people with autism with inclusive research, E Pellicano

To visit any of the links related to this article, click here to go to the ACAMH website.

Referring to:

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Do autistic girls talk differently about social groups?

By Jessica K Edwards

New data, published in the *Journal of Child Psychology and Psychiatry*, suggest that pronoun use during natural conversation might inform us about clinically meaningful social function. Amber Song and colleagues set out to understand whether they could identify natural language markers of social characteristics exhibited by girls and boys with autism. To do so, they recruited 50 school-aged autistic children (17 girls and 33 boys who were matched for level of social impairment) and 37 typically developing children who were matched for age (mean age = 11.35 years) and IQ (mean IQ = 107). They then asked the children to engage in a short, informal conversation. From the conversation sample, the researchers analysed the use of first person (e.g., “we” and “us”) and third person (e.g., “they” and “them”) plural pronouns to determine whether autistic girls and boys talk differently about social groups.

Overall, autistic children used significantly fewer plural pronouns than their typically developing peers, indicating that they talked less about social groups. However, autistic girls talked more about social groups than autistic boys. Yet compared to typically developing girls, autistic girls talked more about groups they were not a part of; this was indicated

This finding is especially important because girls with autism are not as well understood as boys

Julia Parish-Morris

by more frequent use of the pronouns “they” and “them” and less frequent use of “we” and “us”. The researchers speculate that this finding might demonstrate potential awareness of social exclusion in affected girls.

Finally, Song et al. tested whether pronoun use could predict ADOS-2 scores in children with autism. The ADOS-2 consists of semi-structured tasks that involve communication, social interaction, and play to assess different aspects of autism. After controlling for age and IQ, the researchers found that the conversation sample “we” and “they” variants significantly predicted ADOS-2 social affect but not repetitive behaviour scores in girls. Thus, pronoun use might predict individual differences in social function in autistic girls.

“This finding is especially important because girls with autism are not as well understood as boys”, explains study author Julia Parish-Morris. “When we learn more about how girls with autism behave in the real world, it helps us develop personalized supports to address their unique needs most effectively”. Although this study was relatively small, the researchers believe the data serve as a proof-of-concept that natural conversation samples might inform us about clinically meaningful social similarities and differences between girls and boys with autism.

Song et al. now plan to expand their work to include more participants and to collect data using semi-structured question-and-answer formats. From here, they hope to determine whether the identified patterns hold true for other age groups and those with lower, or higher, IQ scores. Future research might then test whether subtle linguistic clues can help improve identification of autism in girls.

Referring to:

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ACAMH CAMHS around the Campfire: Trajectories of autistic social traits in CYP and disordered eating at age 14 years



ACAMH Webinar for parents: Tackling low diagnosis for autism in girls, A Ozsvadjian & M Murin,



JCPP Video Abstract: Anorexia nervosa and autism: a prospective twin cohort study, L Dinkler

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What role does genetic risk play in shaping the developmental patterns of depressive symptoms?

By Jessica K Edwards

Depression with onset during childhood or adolescence is associated with a worse course of illness than depression with onset during adulthood.¹ However, the role of genetic factors in the risk for childhood or adolescent onset depression is unclear. Now, Alexandre Lussier and colleagues in the USA have examined developmental patterns of depressive symptoms and the influence of genetic factors.

Specifically, Lussier et al. examined the relationship between genetic risk for depression and depressive symptom trajectories in >7,000 youths involved in the Avon Longitudinal Study of Parents and Children across a 13-year period from childhood to adolescence — one of the longest periods studied to date. By constructing trajectories of depressive symptoms across development, Lussier et al. were able to classify youth into six classes: high/renitent (27.9%), high/reversing (9.1%), childhood decrease (7.3%), late childhood peak (3.3%), adolescent spike (2.5%), and minimal symptoms (49.9%).

Fluctuations in symptoms between different ages may reflect environmental or learned coping mechanisms, rather than genetic risk

Alexandre Lussier

We found that genetic risk for depression can differentiate between youths with high or low symptoms during early-adolescence, highlighting a period when symptoms linked to genetic risk for depression may be more likely to emerge”, says Lussier. “What’s more, this association holds true regardless of age-associated patterns of responding (i.e., changes due to life events). This means that fluctuations in symptoms between different ages may reflect environmental or learned coping mechanisms, rather than genetic risk”.

Overall, it seems that genetic risk for depression might influence the trajectory of symptoms across development. Going forward, Lussier et al. hope that this finding will ultimately lead to the identification of the genetic risk factors that might help identify those at higher risk for early-onset depression. However, more research is needed to understand the environmental and biological mechanisms driving these depressive symptom trajectories.

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Which perinatal exposures confer a risk of offspring depression?

By Jessica K Edwards

In December 2020, the *Journal of Child Psychology and Psychiatry* published a Research Review authored by Xiangfei Meng and colleagues Yingying Su and Carl D'Arcy on the developmental origins of depression. They focused on exposures in the perinatal period, which includes pregnancy and the first year after birth. We asked the authors to comment on the background to their study, and their main findings from their systematic review and meta-analysis.

“Early life experiences play a profound role in physical and psychological development and health”, says Meng. “In addition, in-utero and perinatal adverse exposures can be biologically embedded via epigenetic changes that can impact on mental health in adolescence and later in adulthood through cellular aging. The literature has consistently shown that some of these adverse childhood experiences lead to adulthood mental disorders, but that evidence has not been comprehensively evaluated and summarized. In our study, we used a multifactorial bio–psycho–social model of in-utero, perinatal conditions to articulate the associations and causal relationships between early life risk exposures and future mental health”.

The authors identified 64 prospective, longitudinal cohort studies that examined the link between 28 perinatal risk exposures and subsequent depression in offspring. In their quantitative analysis, they found that 12 of these factors were significantly associated with an increased risk of offspring depression (Table). These findings provide robust support for the developmental origins of health and disease hypothesis¹ via a bio–psycho–social model. This hypothesis suggests that the quality of foetal development influences the risk for chronic illness (including mental health problems) over the lifespan.

Biological	Psychological	Sociological
Low birth weight (<2.5kg) Premature birth (<37 weeks gestation) Small for gestational age Parents' age <20 years Parents' age ≥35 years	Maternal stress Maternal anxiety Maternal prenatal depression	Maternal education (<9 years of study) Low socioeconomic status Maternal smoking Paternal smoking

Table. Perinatal risk factors significantly associated with risk for depression in offspring.

“While the risk factors identified substantially increase the risk of depression, they are not in themselves necessary and sufficient to cause depression — there are various mitigating and resilient factors that can influence the trajectory from risk exposure to disease”, explains Meng.

“However, within a preventative medicine framework, the identification of these early risk factors of depression has important clinical implications as they highlight the need for primary prevention. Pregnancy and the first years of life are critical windows for the development of depression in offspring, so it is an opportune time to intervene to protect against the generation of mental illness in the next generation.” Going forward, the researchers hope that prospective studies will be established to investigate the effects of paternal attributes and the combined effect of multiple early life risk exposures.

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What are the characteristics of arguments that precede youth suicide?

By Jessica K Edwards

Researchers at Kent State University, USA have studied the characteristics of conflicts or arguments before death by suicide in young people aged 17 years or younger. Erin Orlins and colleagues harnessed data collated by the USA National Violent Death Reporting System that provides extensive narrative details about each case of suicide. Focusing on the year 2017, they identified 197 deaths by suicide that were associated with an interpersonal conflict in youths aged 9-17 years and analysed the narratives of each case to identify any trends.

“Overall, we found that most deaths by suicide occurred within 24 hours following an argument (79 %), and most arguments (70 %) occurred with a family member”, explains researcher Sheryl Chatfield. “Interestingly, we found that technology was either the primary or secondary reason for the argument in almost 25% of cases. We did not find a large proportion of cases that included reports of cyber bullying but instead found descriptions of arguments preceding or associated with restriction in access to technology”.

Chatfield explained that there is disagreement among researchers regarding the role of technology and the internet in the lives of young people: “Although online resources are often viewed as efficient, cost effective, and beneficial, some researchers have expressed concern about the proportion of screen time accrued on a daily basis by youth and adolescents”, she says. “Clearly during the current pandemic, the emphasis of online health-promoting resources and screen time are both increasing”.

Based on their findings, the researchers suggest that clinical practitioners be aware of the potential for extreme responses among some adolescents following technology restrictions. “We suggest there is a need to better understand how young people perceive and interact with technology and the internet — it may not just be a matter of tracking or limiting screen time, but rather gaining better understanding of how virtual social interactions and supports are perceived and relied upon”, suggests Chatfield. “This concept is going to be particularly important when we can safely return to more in-person interactions after relying so heavily on virtual exchanges since early 2020 due to the pandemic. We additionally suggest, based on the range of circumstances and number of times friends and family members described a death by suicide as unexpected, that those who provide suicide risk recognition programming target families of any adolescent — not just those who appear clearly at risk”.

The researchers only analysed data from 2017, which comprised cases from 37 out of 50 US states. They are now expanding their research to assess cases from 2018 and 2019, representing all 50 US states so that they can explore the role of technology through time. “We are also interested in learning other ways technology use or restriction is described proximate to death by suicide”, says Chatfield. “These include use of the internet as a resource for information about suicide, and various ways social media is used preceding death by suicide”.

We found that technology was either the primary or secondary reason for the argument in almost 25% of cases

Sheryl Chatfield

Referring to:

Orlins, E. et al. (2020), Characteristics of interpersonal conflicts preceding youth suicide: analysis of data from the 2017 National Violent Death Reporting System. Child Adolesc. Ment. Health. doi: 10.1111/camh.12439.



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JCPP Annual Research Review: Adolescent mental health in the digital age: facts, fears, and future directions, CL Odgers and MR Jensen

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How effective are tools to help school staff better respond to young people who self-harm?

By Jessica K Edwards

Self-harm among young people is a major public health concern, and now fears are mounting that the COVID-19 pandemic is having an added negative effect on young people's mental health.^{1,2} Although school staff are often the first to notice or hear about concerning self-harm behaviours, reports suggest that school staff often lack confidence and training in responding to this.³ Moreover, some studies have found that initial reactions to students' disclosure of self-harm are often negative.⁴ For this reason, Aureliane Pierret and colleagues at the University of Cambridge carried out a systematic review into the effectiveness, feasibility and acceptability of interventions and tools to support school staff to better respond to young people who disclose self-harm.

Pierret et al. identified eight studies for inclusion in their systematic review, with six reporting on educational and training interventions, and two on management and support tools, for schoolteachers to address self-harm in young people. These ranged from educational websites about self-harm in young people, to protocols outlining pathways to follow when responding to self-harm in schools. In some studies, training for school staff about this topic was given by experienced mental health professionals.

“All eight studies demonstrated effectiveness of these interventions and tools, with an increase in knowledge of school staff regarding how to respond to youth who are self-harming, and an increase in confidence when responding to these situations”, explains Pierret. “In addition, there was generally a reduction in negative attitudes towards self-harm. Notably, however, these self-reported results do not necessarily reflect actual changes in practice, for which no data was collected”. In addition, whilst data was lacking on the feasibility of these interventions, six studies did seem to have acceptable tools or interventions, with high rates of satisfaction and perceived benefit.

“Taking this forward, our findings suggest that a broad range of interventions can be effective and acceptable for schools to improve their staff’s ability to respond to young people who are self-harming, and these can be tailored to the particular needs of each school and the population they serve”, proposes Pierret. “Schools should be encouraged to adopt such trainings or educational tools to hopefully improve mental health outcomes for young people”.

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Pierret, A. et al. (2020), Review: Education and training interventions, and support tools for school staff to adequately respond to young people who disclose self-harm – a systematic literature review of effectiveness, feasibility and acceptability. Child Adolesc. Ment. Health. doi: 10.1111/camh.12436.

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ACAMH CAMHS around the Campfire: Expert discussion of this paper



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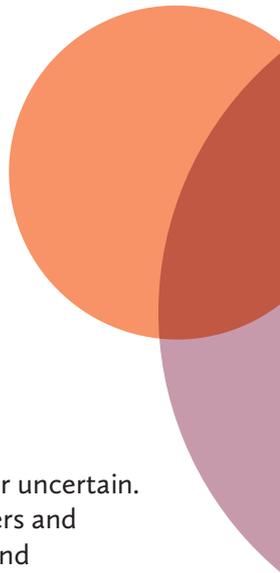
Engaging with UK Parliament on child and adolescent mental health research and policy

Researchers and expert practitioners can contribute to parliamentary work to inform policy-making. Sarah Bunn and Stephanie J Lewis describe why engaging with Parliament is important and explain how this can be done.

Have you ever wondered if UK Parliament is interested in research? Well, the answer is yes, very much so! The value of scientific discovery and expert evidence in policy-making has been brought into sharp focus in a very public way during the pandemic. COVID-19 research has been used in Parliament to inform debates, ministerial question times and select committee inquiries, improving the policy response. Although most parliamentarians do not have a research background, we've seen that they are all faced with the challenge of making decisions on issues about which research

findings may be complex, incomplete or uncertain. It is therefore important that researchers and practitioners engage with Parliament and parliamentarians to highlight and help interpret nuanced evidence. This expert input enhances the use of research in parliamentary activities and can have real influence on the development of legislation, ultimately benefitting everyone.¹

Parliament has recently focused a great deal of time and attention on the topic of mental health. For example, a quick search of UK parliamentary



material in 2021 for “mental health” returns 4,626 individual results when the term was raised in parliamentary debates, questions, statements or reports.² The number of UK parliamentary questions (PQs) including the term “mental health” has increased from 552 in 2012 to 1,408 (and counting) in 2021.² While this may partly reflect an overall increase in the volume of PQs, it illustrates that mental health is an issue that MPs and Peers regularly question Government about. To inform parliamentary work on mental health policy, researchers and practitioners can engage with Parliament in a number of ways, as individuals or as representatives of professional organisations. This article discusses these opportunities in UK Parliament. Similar processes may take place in other countries and specific information about this may be obtained through your institute’s press office or impact team.

Parliamentary Office of Science and Technology

The Parliamentary Office of Science and Technology (POST, based in the UK Parliament) provides parliamentarians with accessible, impartial and trusted analysis of research to inform policy-making. To do this, POST consults experts who inform horizon scanning, identify research literature, and offer perspectives on how research relates to the policy context. Experts also help to peer review briefings and participate in events. To get involved, researchers and practitioners can sign up to POST’s mailing list and respond to relevant aspects of POST’s work programme.³

POST and research counterparts in the devolved parliaments also offer research fellowships, where talented individuals from across the research and practitioner communities come and work in Parliament for three months, usually to lead research work on parliamentary briefings, supported by parliamentary staff. For example, over recent years, four psychiatrists have joined POST for research fellowships, where they produced briefings on the age of criminal responsibility,⁴ and more recent work on the impact of the COVID-19 pandemic on the mental health of children,⁵ adults⁶ and NHS staff.⁷ POST will soon welcome a former social worker for a fellowship to lead a new briefing. There are openings for POST fellowships aimed at PhD candidates,⁸ and through the Academic Fellowship programme for those who are more established in their careers.⁹ These unique experiences provide fellows from various professional backgrounds with the opportunity to step away from their usual work and become

immersed in a stimulating new environment, developing many useful skills to promote the use of research in policy-making.

Parliaments of many other countries have research services similar to POST. A useful list of these services can be found on the European Parliamentary Technology Assessment Network website.¹⁰

Parliamentary Committees

Committees are cross-party groups of backbench MPs or Peers, whose role is to hold Government to account, to challenge whether policies are working and to make recommendations on what Government might do better.¹¹ Select Committees do this by holding inquiries, undertaking briefer pieces of work, and publishing reports, which the Government must respond to. For example, the Commons Health and Social Care Committee is currently undertaking an inquiry on children and young people’s mental health, and the Joint Committee on Human Rights is scrutinising proposals for Mental Health Act reform. Committees on Bills analyse proposed legislation clause by clause, and make amendments that are then debated and further amended in Parliament. For example, the Health and Care Bill Committee is currently reviewing legislative proposals to reform the delivery and organisation of health services in England.

While undertaking this work, committees invite written and oral evidence from the public to inform their understanding of relevant issues, and they really value information that is submitted by researchers and practitioners. Select Committees also appoint external specialist advisors who are experts on the issues being assessed. Researchers and practitioners can find more information on Parliament’s website about current select committee inquiries and the passage of Bills, as well as how to engage with committees.¹² For devolved policy issues, including health and education, in Northern Ireland, Scotland and Wales, information is available online about engaging with committees and research services in the Northern Ireland Assembly, the Scottish Parliament and the Senedd Cymru.

Other engagement opportunities

There are several other routes to engage with Parliament,¹ for example by providing information to the Libraries of both Houses, and by contributing to one of the many all-party parliamentary groups that have interests in particular issues. Of course, researchers and practitioners can also connect with their local MP to highlight topics that are important to them and others in their area. Their MP's role is to represent constituents' interests when scrutinising Government through parliamentary debates, questions and committee work. As constituents, researchers and practitioners can therefore inform their MP's contribution to these policy processes.

If you would like to find out more about engaging with UK Parliament please get in touch. The Knowledge Exchange Unit would be delighted to hear from you! KEU@parliament.uk



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House of Commons Library: Children and young people's mental health – policy, CAMHS services, funding and education

The Mental Health Act White Paper: potential implications for children and young people

Reforms to the Mental Health Act will affect children and young people detained in hospitals. Susan Walker, Bernadka Dubicka and David Kingsley discuss recent proposals for reform and consider their implications for children and young people.

Mental health legislation can reveal much about a society. The detention of people with mental health problems was first regulated in British law in the 18th Century. The 1713 and the 1744 Vagrancy Acts allowed the apprehension of the “furiously mad and dangerous” so that they could be “safely locked up in some secure place”.¹ Overtime, the emphasis on containment of the mentally ill for the protection of society has shifted towards the care and treatment of those with mental ill health. At the beginning of the 20th Century, the 1913 Mental Deficiency Act was defined as “an Act to make further and better provision for the care of feeble-minded and other mentally defective persons”.² The Mental Health Act 1959 and our current Mental Health Act (MHA), established in 1983, introduced more rights for those detained, including shorter admissions, more chances to appeal and entitlement to aftercare services.³

However, in 2017, the then UK Prime Minister, Theresa May, appointed Professor Sir Simon Wessely to carry out an independent review of mental health legislation and practice, with particular focus on why the use of the MHA had been growing so much in recent years, and the decades of over-representation of Black people in the detained population.⁴ In January 2021 the government published the Reforming the Mental Health Act White Paper, which set out the proposed changes to the MHA based on the 154 recommendations from the Wessely review and asked specific questions about



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What happens if the young person does not choose the person with parental responsibility for them? What role would the parents then have in the young person's care?

Susan Walker, Bernadka Dubicka and David Kingsley

these changes in a public consultation which closed at the end of April 2021.⁵ This will inform the creation of a new Mental Health Act Bill.

People working in the field of child and adolescent mental health will probably not be surprised to hear that both the independent MHA review and the White Paper focus primarily on adults. However, some of the proposed changes to the MHA will have significant implications for children and young people with mental health problems, their parents and carers, and the clinicians working with them. Below we discuss five areas of particular relevance.

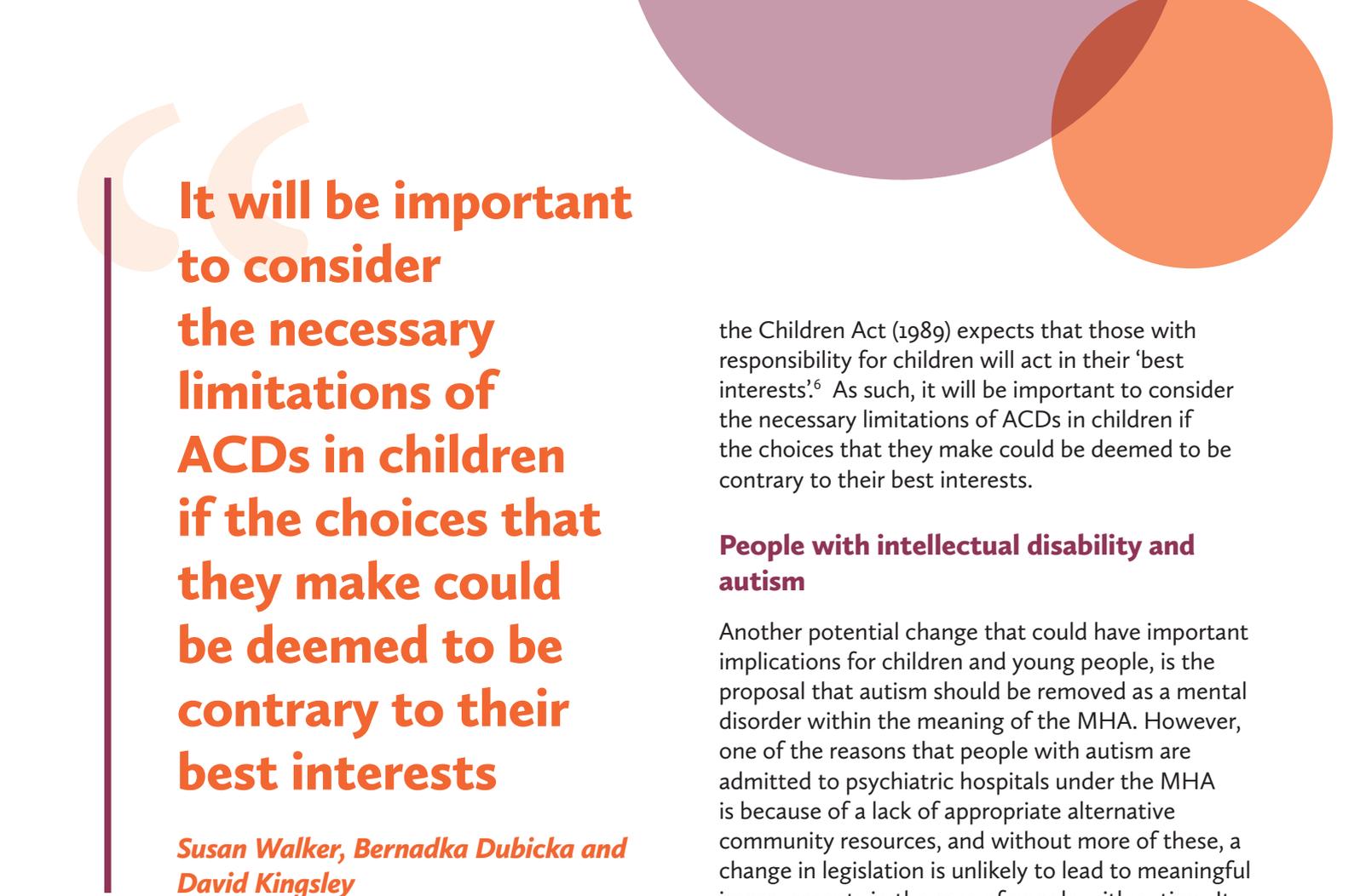
Nominated Person

There is, in fact, only one question in the White Paper consultation that asks specifically about young people under 18. This is in relation to the proposed removal of the Nearest Relative (NR), instead allowing people (with the capacity to do so) the option to nominate someone of their choosing (a Nominated Person, NP). Given the potentially significant powers currently associated with the NR role, including objecting to the detention, applying for discharge, and appealing the detention, this is a very positive change. But the consultation asks specifically whether this option should be extended to those under 16 who are 'Gillick competent'. While it seems appropriate that those under 16 should have the same right to choose an NP as those over 16, it does raise some interesting and potentially tricky issues. What happens if the young person does not choose the person with parental responsibility for them? What role would the parents then have in the young person's care? How do we ensure that the young person is fully informed of the implications of their decision and when should this happen? Can they choose someone under 18? Although the consultation has officially finished, there are ongoing

stakeholder workshops planned to discuss these issues further.

Gillick competence

The White Paper specifies that in order to choose an NP, someone under 16 would need to be 'Gillick competent' but it does not define how this should be assessed. The Wessely review recommended that a formal test of decision-making competence in those under 16 should be included in the new MHA and suggested that this be adapted from the functional test for capacity in s3 of the Mental Capacity Act (MCA).⁴ However, the White Paper states, "The government appreciates that there are different opinions about matters to do with children and young people's rights, and for under 16s matters to do with assessing their capacity and competence. These matters are ultimately for the Code of Practice rather than the act itself and will form a focus for consultation when we come to review the Code".⁵ For the time being, this leaves clinicians without clear and consistent guidance on how to assess the decision-making ability of young people under 16, which given the emphasis on individual choice in the White Paper, will likely be of increasing importance. However, assessment of Gillick competence has implications which extend far beyond the MHA and it would be important to consider this if any formal test was to be included in the new mental health legislation.⁶



It will be important to consider the necessary limitations of ACDs in children if the choices that they make could be deemed to be contrary to their best interests

Susan Walker, Bernadka Dubicka and David Kingsley

Advance Choice Documents

As part of the commitment to ensure people have more say in their treatment, the White Paper proposes the introduction of Advance Choice Documents (ACDs) which would enable people to document preferences in advance, including preferred treatments, treatments they would rather not have, preferred gender of staff, circumstances that might indicate that they have lost the relevant capacity, and religious/cultural requirements. The validity of an ACD will likely depend on whether the person had the relevant capacity at the time it was made, and further clarity is needed as to the circumstances in which the ACD can be overruled. There is no mention in the White Paper about whether ACDs would also be possible for people under 16, and if they are, how competence to make them would be assessed, who would do this and when. In addition, for those under 18, and certainly under 16, it would also be important to consider parental involvement in the creation of an ACD, for example, whether those with parental responsibility have been informed of the contents. The current proposals allow for a person to refuse treatment, “even if the treatment is considered immediately necessary to alleviate serious suffering”.⁵ At present in law it is possible for parents to overrule a child or young person’s refusal to treatment and also

the Children Act (1989) expects that those with responsibility for children will act in their ‘best interests’.⁶ As such, it will be important to consider the necessary limitations of ACDs in children if the choices that they make could be deemed to be contrary to their best interests.

People with intellectual disability and autism

Another potential change that could have important implications for children and young people, is the proposal that autism should be removed as a mental disorder within the meaning of the MHA. However, one of the reasons that people with autism are admitted to psychiatric hospitals under the MHA is because of a lack of appropriate alternative community resources, and without more of these, a change in legislation is unlikely to lead to meaningful improvements in the care of people with autism. It will also be important to ensure that people with autism are not excluded from the right to mental health care under the MHA if this is thought to be necessary.

A further proposal is that people with intellectual disability and autism should not be able to be detained under a section 3 of the MHA. Although the motivation for this is good (to prevent lengthy admissions for people in these groups under the MHA), there is concern about unintended consequences including people being discharged from hospital before their assessment and/or treatment has been completed, or people being held in hospital under the MCA which lacks some of the safeguards of the MHA.

Extension of section 5

The White Paper also asks whether section 5 of the MHA should be extended to enable health professionals to temporarily hold people in A&E who are presenting in crisis. There is concern that fear of detention in A&E might prevent help-seeking. However, currently the MCA is the only provision available to hold someone in A&E and this does not apply to those under 16. The extension of section 5 potentially allows for the safe and legal detention of people who could pose significant risk to themselves or others if allowed to leave A&E, as well as

providing additional safeguards for this population and those working with them.

The introduction of a new mental health act does not happen very often, and it is positive that changes are currently being considered which should increase the rights of people with severe mental health problems. However, legislative changes alone are likely to be of limited impact given the chronic underfunding and staffing crisis within mental health services. The proposed changes will also have major resource and training implications for services that are already over-stretched. At a time of growing demand on mental health services following COVID-19, substantial further investment is needed, including for social care, alongside legislation change in order to address existing health inequalities and improve the experiences and outcomes of those with mental health difficulties, of all ages.

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