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Invisible children: attempting to engage the most vulnerable families

Cullen *et al*[1] describe childhood antecedents of schizophrenia: such prospective studies are rare. Retrospective research suggests that as the number of adverse childhood experiences increases, so does the risk for health problems, including alcohol misuse, ischaemic heart disease, suicide attempts and externalising behaviours.[2,3] However, retrospective studies are prone to the biases associated with recalling early childhood. The best way to fully understand the mechanisms underpinning the relationship between adverse childhood experiences and later development is to follow children prospectively from early childhood.

We had a unique opportunity to achieve this in Glasgow because of the existence of the Women's Reproductive Health Service (WRHS), which provides antenatal care for some of the most vulnerable women in Glasgow: those affected by problem drug or alcohol use or significant mental health or personality problems. This cohort is well characterised in terms of family adversity.

We conducted a feasibility study to see whether it was possible to assess the mental health of the children of very vulnerable mothers. We selected a random sample of ten women who had received antenatal care from the WRHS 7 years earlier. Of the ten children targeted, one was deceased, two had been adopted and one was uncontactable because the mother was in a woman's refuge in a secret location. Of the remaining six, three opted out, one was uncontactable despite repeat attempts, and of the two whose mother provided consent, one then became uncontactable and the last opted out. Each woman received a minimum of ten phone calls and five attempted visits with a letter left each time (unless they had opted out in writing or by phone). Despite two members of staff working full time for 8 weeks, it was not possible to conduct any mental health assessments on these children of very vulnerable mothers. Our research team were able to meet with only two out of our target sample of ten women and did not succeed in assessing any of the children. In other words, despite persistent phone calls and home visits, eight of these vulnerable women and all of their children remain invisible.

The considerable resources available to our research team – including the potential to make multiple phone calls and visits – are not usually open to healthcare or social-care professionals. The question we then have to ask is, how do we reach these most vulnerable of families and safeguard the health of their children?

1 Cullen AE, Fisher HL, Roberts RE, Pariante CM, Laurens KR. Daily stressors and negative life events in children at elevated risk of developing schizophrenia. *Br J Psychiatry* 2014; **204**: 354–60.

2 Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, et al. The 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* 1998; **14**: 245–58.

3 Hillis SD, Anda RF, Felitti VJ, Marchbanks PA. Adverse childhood experiences and sexual risk behaviours in women: a retrospective cohort study. *Fam Plann Perspect* 2001; **33**: 206–11.

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Authors' reply: Notwithstanding the logistical and ethical issues that make this sensitive research difficult to accomplish, we agree that prospective investigations of children followed from early childhood offer the best prospect for identifying mechanisms underpinning the relationship between childhood adversity and later outcomes such as mental health, social functioning, and educational/occupational attainment.

In response to the query regarding how this important research might be achieved given the challenges Sim *et al* identified, we suggest that longitudinal, population record-linkage studies offer excellent capacity to examine these relationships in an unbiased, inclusive, and ethical manner. One such investigation is the New South Wales Child Development Study (http://nsw-cds.com.au) based at the University of New South Wales. This is a longitudinal investigation following the development of a cohort of 87 026 children who entered full-time schooling in 2009 (representing 99.9% of the population). Via local record-linkage infrastructure provided by the Centre for Health and Record Linkage (http://www.cherel.org.au), and operated under strict privacy provisions, anonymised multi-agency records on the children (including health, education, welfare, birth, and developmental records) have been combined by researchers with records on their parents (including health and criminal records).

As part of this study, diverse measures of childhood adversity are available from population-based government child-protection files. Records were available for 3926 children (4.5%) in the cohort by the age of 5 years. These records, in combination with linked information on mental health and well-being outcomes in childhood (and, in due course, in adolescence and adulthood), offer an excellent opportunity to determine the childhood, adolescent, and adult sequelae of early exposure to adversity. Publications from the initial phase of the investigation (spanning birth to 5 years in the population cohort) are currently in preparation.

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The developmental trajectory of bipolar disorder

The article by Duffy *et al*[1] in the February issue tests evidence for a clinical staging model of bipolar disorder for the offspring of parents with lithium-responsive illness and the offspring of parents with lithium-non-responsive illness.

In their analyses, Duffy *et al* were unable to show a statistically significant difference for the risk of any psychiatric disorder between both subgroups of offspring. Yet they still conclude that the offspring of parents with lithium-non-responsive illness manifest neurodevelopmental disorders in childhood and psychotic disorders in young adulthood. A second problem is that the neurodevelopmental disorder category included cluster A