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# Transcript of Interview with Helen Minnis: How can we best support traumatised children?

*This interview was recorded in 2022*

***JANE:***

*Hello and welcome to Helen Minnis, Professor of Child and Adolescent Psychiatry at the University of Glasgow. For many years Helen you've been working therapeutically and researching children who've been abused and neglected and today we're going to be hearing about your focus on researching interventions working with fostered and adopted children and also what your lived experience has been as a black woman, a clinician and a psychiatrist, how that's informed your work with children and families.*

## BeST Services Trial

***JANE:***

*So there's a BeST? Services Trial, that's a randomised controlled trial of an infant mental health intervention for children aged zero to five coming into foster care tell us a little bit about that?*

**HELEN:**

Yes, so that is trialling what we're calling the New Orleans intervention model and that is an amazing model I think. I can see that now because we've collected all of the data and we don't know what the outcome is going to be.

It must have been in 2004 I went and spent time in New Orleans with Charley Zeanah and Julie Larrieu and they had this intervention that they were using for all children coming into foster care under the age of five. It is very linked in with the courts so that the court would kind of manage the system and really support the deadlines and the whole purpose was to work with at-risk families. No one at that time would do anything like that with families where the judge had actually adjudicated that there had been abuse of neglect.

But the purpose of the team, what I absolutely loved about it, is to try and really give the family the best possible chance of changing enough to have the children back. And actually, there was some research using routine data in Louisiana four years after they started doing it, that suggested big reductions in maltreatment of not just children who went home to parents but also subsequent siblings, whether or not the original child had been adopted or had gone home. But because it wasn't a randomised controlled trial you can't be certain that that was due to the intervention and that was really what gave us the springboard to say we want to do a trial of this.

## The New Orleans Intervention Program being adapted to the UK

**JANE:**

*So what were the major factors that you saw in the New Orleans Intervention Program that really attracted you to adopting this in the UK?*

**HELEN:**

For me it was impossible to know at that stage whether it was going to work or not and we still don't know because we haven't finished the trial and we're not going to report until 2024. We will have to wait and see. But for me, what I love about the approach is that you have a specialist multi-disciplinary and mental health team really focused on giving these families who've got into terrible difficulties the best possible chance of getting their children back. And what I loved when I went to New Orleans and what I love about the work of the GIFT and LIFT teams which are our British versions, is that I think clinicians have really learned that pretty much every single family who's got into that really really awful situation, has been trying to do their very best, that many of those families are not only willing to change but can change. And of course there are also families who are willing to change who can't change enough, and that's terribly sad but I just love the kind of value system that accepts families are trying their best, and lets work with that. That's what I love about it.

We're comparing the Glasgow family team and the London family team, our British versions of the New Orleans intervention model, with Social Work. My mum was a social worker and I think she was a really good social worker, and I think good social work tends to do the same thing [as therapeutic interventions]. And so really what we're trying to do in the trial is to see whether an infant health model or a social work model is going to be the best approach. We're just learning loads about these different approaches.

# Challenging the UK practice of Foster Carers being short term carers to prioritise the needs of children?

***JANE:***

*You said to me, just before we started recording this interview, that there's a fundamental difference between the approach in New Orleans and the UK, that foster carers are not seen as long-term carers.*

**HELEN:**

In Britain, yes and I mean to be honest if it doesn't work in the UK, my gut feeling is that might be a really major reason why it doesn't work, and we don't know whether it'll work or not yet. But in New Orleans, Adoption and Safe Families Act of 1997 basically required that there was just a different approach to foster care. Really on the back of that, a lot of states in the United States started jointly registering foster carers as adopters.

What that means is that a foster carer who takes on the care of a child, really is saying, "If this child can't go home, I'm committing to this child for life", but with the understanding that if the birth family is able to change, the child will go home. And that's such a different approach from the way we do it in the UK because in the UK the idea is that foster care is essentially a kind of 'holding situation' until the child can either go back to the birth family or be adopted, so there's a change of placement inherently built into that. And what we've found is that in the UK some foster carers commit to the child for life anyway but actually the system doesn't support that.

So you know there's a whole issue about foster care commitment, and because we were aware of that, we've actually used a wonderful measure that was developed by Mary Dozier called the *This is My Baby or This is My Child Interview*, depending on the age of the child, and it asks foster cares really about the degree to which they think their care of the child is likely to be to be contributing to the child's development. What do they see for the long-term outcome for the child and their role in it?

My colleague Fiona Turner has done some really interesting work looking at the links between foster care commitment and children's outcomes, in terms of attachment disorder symptoms, in other words their ability to really plug into intimate relationships, and their mental health outcomes. We haven't looked at that by group, we haven't looked at that according to whether you've gone to the infant health teams or the social workers, we've just looked at the whole group but it's been fascinating.

# Partnership for Change Trial

***JANE:***

*And you've got another trial going on, one's not enough is it, Helen! You've got at least three trials going on here, which we're going to unpick and find out what's emerging. The second trial is called Partnership for Change whereby you're co-producing an intervention for parents of children who have a social worker, but are not in child protection, with parents of children who do have a social worker. Tell us about that.*

**HELEN:**

Yes, this has been so much fun, we're just at the co-production stage, we haven't started the trial yet, the trial is due to start in October 2022. But it's been such effective work because all the way through the BeST? Services Trial, families, social workers, clinicians they're all saying to us, are we not getting in a bit late here you know, why are we waiting till too many bad things have happened to families, why don't we try and intervene more upstream before the child goes into child protection? And we've always said yes, great idea but that's a different trial. And I think what's really been helpful to us, this trial is funded by an organisation called, *What Works in Children's Social Care*. I think that's a fantastic organisation and they have really strongly encouraged co-production. I think the co-production element is one of the reasons we got the funding.

# Experts by Experience Shaping Services for Children

We've got a scientific co-investigator called Sharon Graham, who is an expert by experience. So she's experienced some of the worst things about being a parent whose child has been in the care system. There's been very, very difficult experiences. But she's really been open about sharing and she has been a fantastic scientific partner because she has got

knowledge that I don't have.  I'm very lucky not to have had my children involved with social work.

And what Sharon has done is she's brought together two groups of parents, they're  called collaborators,  from Glasgow and one in Bromley, south London. And they're working very hard with the GIFT and LIFT teams right at the moment as we speak. There is this phenomenal amount of work going on to try and understand how to modify the two teams.

***JANE:***

*So the GIFT  and LIFT teams are the teams that are adapting this New Orleans model?*

**HELEN:**

Well I wouldn't say that it's just the GIFT and LIFT teams that are adapting it, we're all adapting it with the parent collaborators,  that's really important. So yes the GIFT  and LIFT teams are the new and early intervention model teams that we're trialling in depth and we've got two groups of parent collaborators GIFT  and LIFT.

You know we're having these big development days every couple of months where we all meet and in between there's lots of subgroups. And it's been fascinating work, what we're trying to do that's a little bit different from the way that GIFT and LIFT have worked so far.  They've got these really well evidenced interventions that are very relationship focused and we don't want to fix that because it isn't broken. We love that, that's what they do really well, but what we're trying to add is a poverty aware approach.

# Neurodevelopmental conditions linked with child neglect and abuse

To have a much more kind of hands-on social work welfare rights support for housing insecurity etc approach, and we're trying to introduce more of a focus on neurodevelopmental conditions because one of the things our

research has shown over the last few years, is that children who've experienced abuse and neglect are much more likely to also have problems like ADHD, autism, tic disorders, that kind of thing, that are actually heritable and running in families. So if the children have those problems their parents often have those problems too. So we're trying to better understand how those children and parent problems might interact to make parenting difficult and increase the struggles that the families are having. It's been fascinating work.

# The Influence of Poverty and Other Pressures on Parents

***JANE:***

*I'm interested, Helen, in knowing a bit more about what the parent who has had experience of her children and her family being involved with social services [Sharon Graham], what were the main problems that she's said that she experienced?*

**HELEN:**

She's an amazingly collaborative person and you know she is through the other side of being angry with social workers because I think she realises what an incredibly difficult job they have. But I think what I've really learned from Sharon, and it's not just just a problem with social work, it's also a problem with CAMHS, and I'm a CAMHS clinician, I've got to take this on the chin. We go into meetings with families and we have an agenda, so if I'm a CAMHS clinician I've got 50 minutes and I want to know a complete family history, I've got an agenda. What I really learned from Sharon is that you need to be setting the agenda with parents.

Because there are blooming obvious things that they will be able to see that we can't. She tells an incredibly moving story that is videoed, so it's actually out there, where we interviewed each other actually for an NSPCC conference recently about this.

There was a point when she was on the verge of suicide and there was a street worker who stopped to talk to her for an hour and a half in the middle the night, and just said, “Why are you in this place just now? What’s brought you to this place?” And she said that just completely turned her life around, the fact that somebody was interested in her as a person, what was her journey, what was her story, how did it come to this? I think what I really learned from Sharon on many things, and there's so many things, but a really crucial thing is that every parent who's come to that awful situation of being in such a terrible situation that you know there are child protection concerns about your children. They've had the most massive stresses.

## “Creating Space for Families to Have A Voice”

If you've not come to that situation, you can't, you just can't imagine. It might be to do with your own early trauma but it might be to do with the fact that you don't actually have enough money to feed your kids on a Friday because your money's run out or that you've been sanctioned you've got to go to a food bank and it's really shaming. There's so many pressures that families are experiencing that we just can't imagine.

I think what I’ve really learned what Sharon's really taught me is somehow we need to create space for families in that situation to actually have a voice, to be able to tell us, What can you fix right now that could help and could bring my stress down just enough that I can actually parent the way I want to?”

## Compassion for Parents

***JANE:***

*It sounds like you've got a real feeling for parents, that you feel quite passionately for them. Often what I hear from clinicians is perhaps their difficulty that they might have with parents perhaps not treating a child in quite the way that they want them to. I think quite a lot of clinicians might take the*

*side of a child whereas what I think what you're doing is you're obviously thinking about children very much but in the context of them having parents who can be helped best to parent them.*

**HELEN:**

Yes I do feel passionately about it, and I feel that having that sort of passion for really understanding and being compassionate to parents, is the exact opposite of not being child-centred. Because actually what you realise is that parents want the best for their children as well. And so if you can be compassionate and work alongside parents, then they are allies, and even if for some parents they're in a situation where they are not able to give enough for their children, they're still allies because they can still tell you a lot about the children, they can tell you a lot about how they've got there, they can tell you about their child's journey. However awful the situation for the child is, I think we need to stop being judgmental because we haven't walked in that parent's shoes, and you know goodness knows, if we had, we might be doing a worse job than they were, you know.

So I think it's been a difficult message to get across sometimes because I think sometimes when people hear my passion for being compassionate with parents they think that I'm pulling wool over my eyes and not realising that very occasionally, very, very occasionally there's a parent who is actually sadistic. I've only come across that once in my career. I think it is extremely rare. But for the vast majority of parents, they're just trying their best, and they can help a lot in helping us, together, to understand their child.

# Randomised Controlled Trial of Dyadic Developmental Psychotherapy

***JANE:***

*You're doing a randomised controlled trial of Dyadic Developmental Psychotherapy that was originally developed by Dan Hughes and I know there's*

*been a huge uptake hasn't there in the UK and it's one of the reasons why we featured him as a legacy interviewee on MINDinMIND. Quite a lot of people might not know what DDP is?*

**HELEN:**

It's quite an intensive family-based therapy. The way we're delivering the trial is across approximately three to six months of weekly work, that starts with parents only and then once the child begins to be involved there's still always communication with the parents before the child comes into the room. That's basically so that parents can really get a good understanding of how the child's current behaviour might be related to their past experiences.

You're trying to help the parents understand the roots of their child's behaviour and simultaneously try to improve the way the parents and the child relate together, which is why it's called dyadic, because it's really focusing on the parents in the room. So how is mum and the child relating, how dad and the child relating, how is therapist and mum relating, how's the therapist and the child is relating

It's really complex and to see it done well, is like watching someone conducting an orchestra, it's very, very skilled work. Really the aim is to help the child kind of plug into the parents as parents, because really abused neglected children often don't quite understand what a parent is for.

# Social Work or Therapy for Supporting Parents of Fostered and Adopted Children?

And so DDP is very different from many of the other treatments that are available. Many psychotherapies that are used for children in the care system are individual psychotherapies, where the child comes into the room separately from the parents. A lot of clinicians don't bring the child into the therapy and simply do work with parents alone, or with foster carers.

In other parts of the country, there are this group of families who really don't get much access to therapeutic services and tend to be kind of held by social work.

***JANE:***

*So what's emerging from that study so far Helen?*

**HELEN:**

Phase one findings have been absolutely fascinating and this is before we even started randomising. What we found is that the services for adoptive foster families of this age group of children across the UK is a patchwork. It's a postcode lottery, what you get is going to depend on where you are, and my colleague Verity Westgate who's the trial manager for the English sites, she's done some fantastic work mapping services and feasibility sites.

So at the moment we're involving an NHS site in Scotland, a third sector site around Milton Keynes, and a site in Oxfordshire where DDP is delivered through social care. So that in itself tells you DDP is delivered in all of these different contexts which is really challenging. So that's kind of the background in which we're trying to do this trial. Whatever we find about DDP is going to be really important for policy moving forward. Whatever we do in future, we've got to make services for this group of families more coherent because there's such a patchwork at the moment.

***JANE:***

*And so this trial is just with children who've been adopted and fostered isn't it?*

**HELEN:**

That's right, yes, to take part in the trial we're recruiting families with children aged 5 to 12 who are either adopted or in permanent foster placements. That's because this really was based on a lot of discussions with Dan himself and also other experts in the UK, people like Ben Gurney

Smith and Kim Golding, to settle on who do we want to do this first randomised controlled trial of DDP with?

# The Importance of Safe Placements and Therapeutic Work

We settled on this group because the whole ethos of DDP is to really try hand over the reins to families, to really get them in the driving seat, help them feel confident in parenting children who've had early trauma. So it's really important that these are the 'forever families', that they are the families who are committed to the children, because the last thing you want is to do that really challenging therapeutic work and for the child not to feel safe in that placement.

So it's been and it's been a really fantastic kind of journey working with Dan and other colleagues, who are experts in DDP. We've been working together to try and develop this trial for well over a decade and Dan has always been completely open to research. He said something really inspiring once, we got the funding ready to start, he said, "You know what, if we were to find out that DDP wasn't a cost effective intervention, what we would do is we would get right down to understanding how to modify and make it better." As far as I'm concerned, that's the best attitude and it means that whatever we find in the study is going to be helpful.

# What are the Main Predictors of Successful Adoptions?

***JANE:***

*What do you think the main predictors are of successful adoptions?*

**HELEN:**

Wow what a big question! So I am basing this not on research, I'm basing this on my clinical experience and my reading of lots of research. I think

there are two really big important things. One is the support that the adoptive family gets and there was some work that was done in Bath many years ago where they used an approach that every single adoptive family who had a child placed with them for the first time got a really intensive sort of therapeutically supportive first meeting and then it was decided where they would from there. About a third of the families didn't need anything else but a third of the families needed a bit of work and about a third of the family needed a lot of work.

You know they didn't have a single adoption breakdown in about 10 years. It's quite incredible. I think for me a recognition that adoptive families need the potential for support is crucial.

## Some Adopted Children are More Resilient than Others

The other really important factor and this is a really important message for adoptive families, is that it depends a lot on what the child brings to the family. Some children come into adoptive families without any mental health problems and we don't really know why some children are just more resilient in terms of their mental health. Probably about a third of adopted children it just all fits, and everything goes fine. I really do not believe that's to do with the parenting that they've been offered, actually, because in my experience I've met hundreds of adoptive families and my goodness they are dedicated to their children and as a group they are super parents.

Our previous research has shown very clearly that children who come into the care system are much much more likely to have these heritable problems things like ADHD, autism, tic disorders. If children have good enough parenting in the first few years of life, they are absolutely fine and some of them are just lucky that their type of ADHD or autism doesn't create huge problems for parents. But some of those children, especially if on top of that they've developed problems signalling their needs, then those children can be extremely difficult for parents to give their love to.

Those children are not ready to accept it, and it's such a sad thing when you see that, especially because it is so fixable.

## Traumatised Children Who Can't Ask For Help

If you've got a young child who for example has ADHD and because of his ADHD is more prone to flying off the handle, having temper tantrums. If there wasn't anything else going on with those families, they would just get to know that child and they'd be able to deal with it. But if that child doesn't understand what parents are for, if that child also doesn't realise that those parents are there to help, so they won't ask for help when things are difficult, they won't tell their parents if they skin their knee or they've got a tummy ache. And so unless you're somehow psychic, and none of us are, then you won't realise that that child is getting more and more stressed. Because of their early trauma they just may not actually relate those feelings and then suddenly, bam! the child is unpredictably flying off the handle.

You know that would be hard for any parent. We did a study a few years ago where we were doing really comprehensive assessments of children of this age group, primary aged children who had mental health problems and were in adoptive families and sometimes our research assistants had migraines at the end of the morning because the level of problems that these children had were really hard to deal with. They would have been hard for any parent, and unfortunately I think what often happens with these otherwise really well functioning parents, is that by the time they come to services they're desperate.

And what we do in our judgemental pathways, is we say, "Oh that must be difficult, you must have caused this". What I think 99.9 times out of 100, that is not the case, this family has a really really challenging parenting task because they've got a person with problems who doesn't know how to ask for help. So I think understanding that the kind of support needed by adoptive families, permanent foster families, needs to include an understanding that children may well have real kind of CAMHS workload type of problems and we need to be looking for those as well as trauma

related problems. If we could get that right, we could be really preventing a lot of adoption breakdowns.

# Supporting Adoptive and Foster Parents

**JANE:**

*So given your research Helen in this area, what changes would you like to see implemented in regard to what we do with maltreated children who come into the care system?*

**HELEN:**

So if I could weave a magic wand there would be an assumption that every substitute family, whether they're a foster family a kinship family or extended family or an adopted family, are going to require additional support. So an assumption that a child who has had to come into the care system is likely to have additional needs. We need to stop treating these families as if love is going to be enough, because it usually isn't. There needs to be at the very least, and sometimes it's only a very light touch that's needed, but at the very least I think families need to be supported to understand this thing that often children who've been abused and neglected don't quite get how to ask to have their needs met in an ordinary way.

***JANE:***

*It doesn't sound like you know you're being extravagant at all that you're asking for, it's something that's really an obvious thing to do. As a psychotherapist and having treated fostered and adopted children, it's not that we haven't known this for an awful long time is it.*

# Attachment Disorders affecting fostered and adopted children

**HELEN:**

I think there are two problems with the kind of support that's needed. The first one I think is that problems like reactive attachment disorder and disinhibited social engagement disorder, if you want to use the disorder terms, are difficult to spot as problems. So reactive attachment disorder is just essentially where children really don't signal their needs, they don't seek comfort, they don't accept comfort, or they do it in a very minimal way that you can miss it. If you happen to blink, you would have missed that child is sayinG, "Mum, I've got a stomach ache." Because we are primed as adults for our brains to light up when a baby cries, so if a baby doesn't cry our brains don't light up. So we're not primed to notice that.

And then disinhibited social engagement disorder, which is the other trauma related problem that some children get if they've been abused or neglected, is in some ways even more tricky because children seem loving until you realise that they're just as loving with the postman as they are with the carers. So they don't understand intimacy. Virtually all children who are in the care system have some problems with signalling their needs even if they don't quite meet these diagnostic criteria.

So it's really difficult because these are invisible problems and problems that we're primed not to notice. The second really big problem I think in clinical services is an assumption that children's problems are entirely trauma related and what our research has shown as I've said a couple of times earlier today is that actually these children are even more at risk of having non-trauma related problems, so ADHD, tic disorders, intellectual disabilities, autism, the rates of these things are higher in this population and I suspect, we don't know this, I suspect that it may be because they are running families. If you're a parent with a problem like this and a child has a problem like this and you're living in poverty and you've got insecure housing, you've got a toxic mixture out of which ill-treatment might arise. So I think one of the real mistakes we make is to forget that not only do these children need support but they need ordinary holistic CAMHS support.

We at least need to be looking for all of these problems and not making assumptions about the roots of a child's behavioural difficulties if that makes sense.

***JANE:***

*Yes, I think what does make sense is this is coming from someone who has had such a long interest in fostered and adopted children. What sparked your interest in this area?*

**HELEN:**

Gosh, such an interesting question. I mean I've often asked myself that, and I think it was quite accidental. My mother was a social worker, she was a social worker back in the day when you know you got to have a caseload and that was your caseload. My mum was really good at confidentiality but sometimes she'd come home on a Friday night and she'd say, "Oh my god Mrs X's husband's drunk all the money, and I've had to make an emergency payment." So I got a real insight from her into I guess the challenges of being a struggling family. And I actually remember at one point she couldn't get anyone to drop a little boy in foster care to school, so we used to drop him off on the way to school.

And then after I studied medicine, all I wanted to do was travel, I didn't know why I just wanted to go somewhere interesting that wasn't Britain. So I spent quite a few years kind of training myself up to have enough obstetrics and casualty experience and things to go to another country. I just got whatever job was available. When I got a job in an orphanage in Guatemala, this was before I did any mental health training at all, but I ended up in an orphanage as the orphanage doctor and also essentially the GP for the surrounding villages. Because I wanted to train in psychiatry, I'd gone to speak to Professor Eric Taylor. He has been a real mentor to me, what an amazing clinical academic. He's most known for his work on ADHD, but I basically asked for a meeting with him because I wanted to go into psychiatry, I wanted to go to the Maudsley which is very research based. And he said, "Oh I'm on panel for the new ICD-10 as it was back then, we're now on ICD-11, that's the International Classification of Diseases of the World's Health Organisation, and they were developing the new then new diagnostic criteria for reactive attachment disorder. He sent me a copy of this and said that I might find it interesting to think about it when I'm there.

# How Experience in an Orphanage Sparked a Career With Adopted and Fostered Children

I literally landed up in this orphanage in Guatemala, and immediately as a stranger I was just covered with  little children under five. I just had children all over me and I literally couldn't walk forward until I peeled them off.  I was madly reading trying to get myself through John Bowlby's trilogy, ' Attachment, separation and loss'.

Then it wasn't until I did my first home visits in the local villages as a local GP that I realised that that was really abnormal because these families were living in absolute poverty.  They were much much materially worse off than the children in the orphanage, didn't have three meals a day, they didn't have chlorinated water etc but I would walk into these very very materially poor families and the children would hide behind their mother skirts just like John Bowlby said they would! They had stranger anxiety and you would see beautiful parent interaction, you'd see a young dad talking to his infant and just doing what is done all over the world.  These kids were getting great care even though their families were really poor and then in the orphanage kids were getting a rotating stream of worthy volunteers who they couldn't form proper attachments with.

So that was where it all started for me and I just thought wow this is so interesting I want to understand it more and I've been trying to understand it the rest of my career.

# A Pioneering Black Psychiatrist

***JANE:***

*I'm wondering how your lived experiences as a black woman and clinician have informed your research?*

**HELEN:**

That's such an interesting question, I'm really glad you asked it. So I think I'm only realising now the extent to which it's informed my experience because when I was a wee trainee in psychiatry and myself and my colleague Gladys Smith who was a very prominent general adult psychiatrist,we were the first two black female psychiatric trainees at the Maudsley. There was a trainee called Kwame McKenzie he's now in Canada, who was the first black trainee, and he'd been in the cohort above us, he took me and Gladys to one side and he said, "Can I just give you a bit of advice, become a psychiatrist before you become a black psychiatrist." And I'm so glad he did, because it meant that I then could focus my career on what I'm really interested in, in families. But I think as a black woman working in largely white spaces you unconsciously experience that sense of being other, and W. E. B Du Bois, a fantastic American philosopher from the 19th century, described this thing of double consciousness which is where if you're black in white spaces you have to think about how you're perceived as well as how the person you're talking to perceives you. I've become very aware since I became a professor that a lot of people you are talking to think you don't look like a professor. I'm thinking, 'Yes this is what a professor looks like, this is what science looks like'. So I think that gives you skills in recognizing when other people in the room are having an experience of being other and I think it's made it much much easier for me to really relate to families who are really struggling.

A good example was in Guatemala. When I arrived I had no idea what an incredibly racist society that was, and it really was white at the top, latino which were the kind of white Guatemalans and indigenous were somewhere way below and then black down in the basement. So I arrived as a black doctor and there had been a white Swedish volunteer with no medical training running the clinic before me using a book called Where There is No Doctor. She had done a really good job considering she had no training.

I came into the local indigenous communities who'd experienced terrible oppression and had lived in this society with this hierarchy and they just looked at me and they thought you're not a Doctor! And I could just tell immediately they had absolutely no belief in my medical skills. But of

course I was a doctor, and so within literally about a fortnight I'd actually cured a couple of pneumonias, I got some people started on medication for their anaemia, and started some treatment for malaria. And they were going, "actually, she knows what she's doing". But they didn't have that fear of me as a big scary person and so bizarrely after about three months,oh my goodness I was in that community. I was really in that community, and even the local witchdoctor's wife we became buddies, even though he saw me as a business rival because I wasn't charging. So there was a kind of pulling in that the Swedish volunteer could never have had because she was seen as this big scary. So I think that's been a wonderful, wonderful side effect of being a black psychiatrist.

**JANE:**

*It's very moving Helen, and I'd imagine that families who you work with here in the UK as well, pick up that sort of willingness in you to actually be relatable and to really try and understand what's going on for them.*

**HELEN:**

I'm so glad you asked that question because in recent years I've been asked to talk about race and psychiatry or just racism in general and I've always avoided it because of Kwame McKenzie's advice. And then my daughter Ellie when I was asked to do this lecture about racism, she said, look mum you're a senior now you just got to take it on the shoulder. But it's been really fascinating because what I've learned is that although clearly race is a toxic horrible thing, it's had much more negative effects, far far greater negative effects on many people that I know than I experienced because I grew up in Scotland where I didn't have low expectations. I think mainly because back in the 1970s, there were very few black people, they were nearly all doctors and PhD students, so Scottish people thought you must be one of those brainy black people. Which was not the experience of black people in most parts of the world. I think that was very important for me, I didn't grow up with low expectations. But of course I've experienced racism, I've experienced negative sides, but for me actually as a scientist I realise it's been incredibly positive, it's built skills for me that I wouldn't have had. I think

it's allowed me to do these complex trials because you've got to work with such a range of people.

My daughter Ellie, she's a management consultant. She says she's so aware of this double consciousness, it's so much more talked about in the United States. She says, “I am learning to speak CEO”. It's like learning to speak Swahili or Spanish, she's learning to speak chief executive. I think being aware that there’s a language that she can learn as a young black woman, is a huge advantage. To realise that it actually might be difficult being in this very very white space that she's in in some ways, but actually she's developing skills.

***JANE:***

*I think the Adoption and Foster world is very lucky to have all your skills Helen and what you’re doing hopefully is going to make a really positive difference to children's outcomes.*

**HELEN:**

I hope so, it's always scary doing trials because one of the reasons we do randomised controlled trials is because psychological interventions can be harmful and you always worry a little bit you know, are we trialling something that ends up having harms? But I think because we've got so much quality work going on and we've got specific independent committees overseeing everything, I think that's unlikely. But we've got to be open to the fact, we hope that these interventions are beneficial but if they aren't then we'll learn a lot about what to do better next time.

***JANE:***

*We'll come back to you when the trials are in and when you’ve done your evaluation, it will be great to get an update and good luck with the rest of it.*

**HELEN:**

Thank you so much.

***JANE:***

*You're welcome Helen, thanks for your time.*