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Promoting the mental health of children in need

It is as important to protect and promote good mental health in children, as it is to detect and respond to mental health problems should they occur. Differing ways of thinking about mental health and differing forms of professional practice have sometimes made it difficult to build a consensus on just how this might be achieved.

PROMOTING GOOD MENTAL HEALTH

The ‘medical’ model has tended to treat mental health like any other ‘physical’ condition, looking for explanations in genetics or in the chemistry of the brain, whereas the ‘social’ model has tended to treat it as socially constructed and culturally defined. It is however necessary for all professionals to achieve a constructive synthesis of ‘social’ and ‘medical’ models of mental health because effective help will depend on being able to draw on shared aims and responses from a range of sources and professional perspectives. Similarly, it has become less necessary to try to resolve the ‘nature versus nurture’ debate, than to be aware of how both interact in the lives and developmental progress of individual children.

For example, for a child with Attention Deficit Hyperactivity Disorder (ADHD), the process of diagnosis, medical treatment, educational and social management requires multi-professional input. The medical role is to classify according to agreed (ICD10) diagnostic criteria and offer the option of medication. Parents, teachers and social care workers will seek to provide a structured environment responsive to the child’s needs (clear boundaries and minimised distractions), reinforcing strengths such as impulsive creativity and directed physical activity, and reducing unwanted behaviours such as poor impulse control and aggression.

There is a very real problem of perceived stigmatisation of a child who might require or receive a ‘diagnostic label’ or mental health services. Professionals must be conscious of this and be ready to challenge negative attitudes to mental illness as well as to assure service users of confidentiality and a commitment to working in partnership.

WHAT IS GOOD MENTAL HEALTH?

There is some consensus that, taking into account the developmental nature of both body and mind through childhood and adolescence, good mental health in young people is indicated by:

- their capacity to enter into and sustain mutually satisfying personal relationships (‘secure attachment behaviour’)
- continuing progression of psychological development
- their ability to play and learn so that attainments are appropriate for age and intellectual level
- the development of a sense of right and wrong
- any psychological distress or maladaptive behaviour being within the usual limits for a child’s age and context.

When trying to describe or assess difficulties in any of these areas, it is

objective 6 To ensure that children in need and children looked after gain maximum life chance benefits from educational opportunities, health care and social care
 living in families or other appropriate settings in the community where their assessed needs are adequately met and reviewed

objectives 3 & 4

useful to distinguish between the following categories (remembering that figures quoted may not be directly comparable because of varying populations and definitions in different research studies).

- **mental health problems** These are relatively common, affecting 30-40% of all children at some time during childhood. They are likely to be mild and transient and may arise from a broad range and combination of congenital, physiological or environmental factors. It is important to note that perfectly healthy development will include displays of behaviour over which adults may be concerned. For instance, primary school children display on average three or four 'undesirable' behaviours that adults would like them to modify, including, for example, poor concentration, aggression, lying, stealing, tantrums, toileting or bedtime problems, food fads, specific fears, anxiety or timidity. Examples in older young people might include difficulties in personal relationships, or behaviours that the young person or others find troublesome or worrying (such as poor anger control, difficulties in maintaining friendships, experiencing bullying, conflict with adults around appearance, school progress or household rules). Most often, these phenomena reach a resolution without formal intervention, and the episode is usually accompanied by psychological growth.
- **mental disorders** These are problems that meet the criteria of the internationally recognised classification system for mental disorders. Such disorders usually have a persistent and serious effect on how a child functions at home, in school or more generally. Examples would include, Tourette's Syndrome (involuntary movements or 'tics' along with involuntary use of obscene language), Post Traumatic Stress Disorder, (intrusive re-experiencing of trauma, generalised anxiety and avoidance of 'reminder' situations) and disorders such as Attention Deficit Hyperactivity Disorder (ADHD) (overactivity, impulsivity and distractibility with poor attention control) or Conduct Disorder (CD) (a description of a range of oppositional, antisocial, violent or illegal behaviours). The prevalence of mental disorders varies with age and circumstance. A recent national survey in England reports rates of mental disorder to be 8% for five to ten year olds living in private households compared with 42% for Looked After Children of the same age group. Rates for 11 to 15 year olds were 11% and 49% respectively. The prevalence of mental disorder varies with ethnicity, with higher rates reported for black children than for white, and much lower rates amongst children of south east Asian ethnic origin (Indian lower than Pakistani and Bangladeshi). Boys at all ages are much more likely than girls to have ADHD or CD, as well as language and communication problems; teenage girls are more likely than boys to have depression or eating disorders.
- **mental illness** This refers to relatively rare and much more severe conditions which affect a smaller number of all children at some time during childhood. It includes severe depressive illnesses (up to 2.5% of children aged under 11; up to 8% of 12-16 year olds), anorexia nervosa (up to 1% of 12-19 year olds), and psychotic disorders such as schizophrenia.

It is not uncommon in those groups of children and families with mental health needs that come to the attention of service providers to find associated problems with heavy and problematic use of substances. Mental disorder is three times more common among young people who drink alcohol on a frequent basis and five times more common among those who regularly use cannabis. The present state of research suggests that, more often than being causally related, the presence of a mental disorder and problematic use of substances represents exposure to risk factors associated with both sets of problems.

There is evidence to suggest that many child and adolescent mental health disorders become more complex and resistant to treatment with time. In particular, conduct disorders in childhood are associated with a high risk of adult antisocial behaviour disorders. This puts a premium on early and effective intervention. However, it has been estimated that only 10% of children with a disorder are in contact with specialist services. Some children with more serious problems (such as severe depression) are less likely to reach appropriate services, while those with more obvious and more burdensome (to adults) behavioural or conduct disorders are more likely to receive services (but not always appropriate ones).

RISK FACTORS

While it may not be possible to achieve a consensual definition of mental health, there is strong evidence of what risk factors are associated with mental health problems, disorders and psychiatric illness. These factors are cumulative in their effect. Children with mental health problems in Great Britain are more likely to have a combination of deprivation-associated factors such as:

- poor physical health
- special educational needs
- learning difficulties
- parents with mental health problems
- family discord, instability or disruption
- greater experience of punishment by parents
- experience of more stressful life events
- experience of any form of physical, sexual, emotional abuse or neglect.

In so far as many of these risk factors are also indicators of deprivation and social exclusion, the population of children 'in need' is particularly at risk, with those looked after possibly the most at risk. UK Studies have indicated that between 33% and 90% of children Looked After have mental health problems of clinical significance. Other studies have suggested that just under one in five care leavers had mental health disorders such as depression, eating disorders and phobias. Over one third had deliberately self-harmed since the age of 15. Other clearly identified risk groups of children include: those adopted following abuse; those living in refuges from domestic violence, those in the youth justice system and those in homeless, refugee and asylum seeking families.

Children and young people who have multiple placements and frequent disruptions, or prolonged placements with frustration of permanency plans require close attention and assessment. Such children may have undetected problems with attachment, attention, learning or communication. Research into the health care of children Looked After has indicated that insufficient attention is paid to continuity of health care, health protection and health

promotion. This will often mean that information about a child's medical history will be 'lost' and that the child will receive little by way of health education, both of which can have consequences for the assessment and management of any particular mental health need. The Assessment Framework for children in need is an important addition to the overall strategy for identification and management of children with mental health problems. The Strengths and Difficulties Questionnaire (SDQ) is a screening tool that can be administered to children, young people or carers and is validated to indicate when there is a need for fuller psychological assessment and possible intervention. This is a valuable addition to early identification and intervention strategies.

The experiences of some children in need have been shown to have possible short and long term consequences in terms of their mental health. Physical abuse, domestic violence, sexual abuse or neglect of sexual boundaries are high risk factors for mental disorders such as depression, anxiety, self-harm and Post Traumatic Stress Disorder (PTSD).

RESILIENCE

Before considering in more detail 'what helps' both in terms of service structures and direct work, it is necessary to mention an important protective factor that mediates, to greater or lesser degrees, against all of the risk factors discussed thus far – resilience.

Resilience is a key factor in protecting and promoting good mental health. It is the quality of being able to deal with the ups and downs of life, and is predicated on self-esteem. This in turn is generated by secure early attachments, the confidence of being loved and valued by one's family and friends, a clear sense of self identity (personal, cultural and spiritual), a sense of agency and self efficacy (being able to make decisions and act independently) and the confidence to set goals and attempt to achieve them. Even in disrupted families, and following adverse or abusive experiences, children can develop resilience as long as they have some positive interactions and experiences. These may be a confiding relationship with an adult who develops and reinforces the child's sense of self worth (carer, teacher, coach, religious leader, friend) school success (recognition of achievement or effort) or sporting success (both participating and winning).

As well as taking steps to promote self-esteem, it is sensible to avoid events and circumstances that tend to render the child powerless; for example, by excluding children from the process of critical decision-making. Such experiences have the reverse effect on self-esteem and thus on mental health.

The importance and yet the difficulty of promoting resilience can be seen in the following example. Intra-familial sexual abuse presents a substantial risk to the child's mental health, both directly through the abusive behaviour(s) but also indirectly through the messages sent to the child about the lack of parental esteem and respect for the child's autonomy. The parent's objectification of the child may teach him or her to feel intrinsically worthless, with low self-esteem. Intervention at this point should clearly aim to protect the child from further abuse but also try explicitly to raise their self-esteem. The sexually abused child's feelings of guilt and worthlessness can generate acting out and challenging behaviour. Social and peer group isolation then makes them particularly vulnerable to

targeting and grooming into bullying, abusive relationships and future emotional or sexual exploitation. The interruption of this cycle by promoting the child's feelings of self worth and thus the ability to offer and accept friendship (reciprocity in relationships rather than continuous emotional over-dependence on others) is an outward and visible sign of resilience.

PRIMARY PREVENTION

Work that seeks to promote resilience makes sound preventive sense. It might include engaging the child in activities that build self-esteem by promoting positive, confiding interactions with an adult role model and the development of problem solving and life skills. Promoting health seeking behaviour by ensuring effective links with health professionals at routine and opportunistic consultation is an important task for social workers, as is monitoring educational progress for early identification of problems at school. For Looked After children, avoiding unnecessary moves in placement through detailed care planning (including a recruitment, training and support strategy for foster carers) will reduce risks as will the careful matching of carers to take into account the developmental, temperamental, social and cultural needs of children.

Research suggests that:

- **the earlier in a child's life preventive work begins, the more likely it is to be effective**
- **preventive work needs to be disorder, context and objective specific** (Focused, highly structured programmes targeting risk factors or problem behaviours are more beneficial than generic, unstructured interventions such as providing counselling or group discussion. Often it will be the number rather than the type of risk factors that will determine outcome and there may be interaction between risk factors.)
- **longer term strategies are more likely to be helpful than short lived initiatives**
- **interventions which focus on systems or contexts within which children live (e.g. school, family, neighbourhood) as well as on the child are more likely to be successful than interventions which focus on the child alone.**

SERVICE RESPONSES

Following national recommendations concerning the organisation of Child and Adolescent Mental Health Services (CAMHS), services for children and young people with mental health needs are being organised to reflect responses at four levels or 'tiers'. The 'tier one mental health worker' provides 'front line direct contact' services to the public. Child care social workers, General Practitioners, teachers, health visitors, school nurses and community paediatricians may all be involved in offering 'tier one' services, and should aim to offer timely first line therapeutic input (such as behavioural interventions). This should be underpinned by appropriate professional training and development, as well as by advice and support from 'tier two' mental health professionals.

Research has indicated that recognition of disorders at 'tier one' is inadequate, despite evidence to suggest that mild to moderate problems may be amenable to prevention or early intervention. The evidence for

what helps

successful outcomes of intervention at this level is sparse and inconclusive, although there is some support for the benefits of short training courses for primary care professionals in increasing their skills and confidence in behavioural management. Much needs to be done to improve links between specialist services and the rest, especially in terms of providing consultation and support to 'tier one' services. At present, only 2% of specialist time is spent in providing consultation to others.

In some areas, access to specialist services can be poor. Since there is evidence that children whose parents have mental health problems are at greater risk, attention should be paid also to the degree of integration between adult and children's services.

As well as trying to ensure improved co-ordination (at all levels), it is important to make information and advice more widely available. Advice for parents and young people is provided by a range of organisations, often via their websites (see Useful Research Resources).

The 'second tier' of services offers specialist provision and includes specialist social workers, educational psychologists, paediatricians and first line Child and Adolescent Mental Health (CAMHS) professionals (psychiatrists, psychologists and community psychiatric nurses). All may help children with behaviour problems unresponsive to first tier interventions, or those with associated learning or physical problems (such as impaired hearing, dyslexia or dyspraxia).

The 'third tier' comprises specialist services for those with still more severe or complex disorders for whom a specific care plan is required involving several agencies and perhaps specialist clinics or day patient facilities (such as for substance misuse, ADHD, eating disorders).

The 'fourth tier' includes very specialised services unlikely to be provided in each locality, such as inpatient psychiatric services, secure beds or specialist residential care. There is some evidence to suggest that services are increasingly being organised on this kind of strategic basis.

Improving service responses both between tiers and at each level will usually require:

- **creating multi-agency ownership of the mental health problems encountered by children, young people and their families**
- **recognition of the part that each agency must play in developing local services, supported by a strategy guaranteed by the leaders of each agency**
- **services planned on the basis of the actual and assessed needs of the child population rather than on historical factors, following a careful mapping and audit of current services**
- **offering services that have demonstrable effectiveness.**
(This is predicated on a specific intervention offered for an identified diagnosis. Given that identification of mental health disorders and illness is poor, a mental health screening tool for children with risk factors is probably required.)

THERAPEUTIC SERVICES - WHAT WORKS?

Certain general statements can be made about what works in responding to a child's mental health needs, such as 'specific cognitive behavioural therapy packages are effective in moderate to severe anxiety or depression'. But the wide range of problems, severities and contexts experienced by children means that this sort of statement is of limited value in helping a

worker improve a specific child's mental health. The general principle holds, that accurate assessment and a specific targeted intervention is required.

The age of the child is an important consideration in responding to possible mental health problems and workers need to be confident that they have a clear understanding of child growth and development. Early responses to post-natal depression (which affects 10-15% of women and which is associated with later attachment disorders, developmental delay and behaviour problems in their children) should be given a high priority and should involve close liaison with health visitors and the carefully co-ordinated and regular provision of emotional and practical support in appropriate child-rearing. Training in parenting skills can help. Intensive training (including problem-solving skills) for parents of children aged four to eight with behaviour problems has shown positive outcomes maintained at one-year follow-up. A systematic review of family and parenting interventions for young people with conduct disorder has shown beneficial effects on reducing time spent in institutions.

The middle school years and early adolescence are accompanied by higher rates of conduct and emotional disorders. Interventions that target stress at school (e.g. reading recovery schemes, anti-bullying strategies in schools, drug and alcohol education) as well as strategies to help with inadequate or inappropriate parenting may prove effective. It should be noted that a child displaying acting out behaviour (following abuse or change of placement) might be reacting appropriately to their situation. This may be uncomfortable for adults but the child will respond to reassurance, understanding, support and, if necessary, a behavioural approach.

Suicide is rare below the age of 14 but deliberate self-harm is most common in adolescent women and is the most common reason for acute medical admission of young people. Brief intervention (e.g. problem-solving or solution-focused) with families following a suicide attempt may help, although evidence is slight. Educational programmes that promote personal control and problem solving, targeted at high-risk adolescents, may help to reduce risk. Economic and social pressures, custody, bullying, rural isolation and physical and sexual abuse have been identified as specific risk factors for suicide and deliberate self-harm in young people. There is clinical consensus that all adolescent expressions of intended suicide should be taken very seriously and lead to assessment by specialists.

With older adolescents, the clearest association between mental health problems is that with previous psychiatric illness and drug and alcohol misuse. Tackling substance misuse calls for the provision of accurate information, advice and support and easy access to counselling services and harm reduction measures (such as needle exchange).

Particular attention should be paid to achieving access to services for vulnerable individuals such as those who are homeless or in custody. Analysis of psychosocial therapies for adolescents shows that group therapies carry a risk of making behaviour problems worse. Parent training is ineffective in modifying child behaviour in this age group. Multi-modal, intensive, community based, highly structured and well-integrated programmes focusing on goals relating to offending behaviour (multi-systemic therapy) is effective, even for troubled and disorganised families.

KEY TEXTS

RESEARCH

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USEFUL WEB RESOURCES (CHECKED ON 15 OCTOBER 2003)

www.rcpsych.ac.uk/info/index.htm – Royal College of Psychiatrists – useful reports and fact sheets available online on mental health topics as well as mental disorders and illness.

www.youngminds.org.uk – Children's mental health charity – offers information resources, magazine, training and consultancy.

www.nimh.nih.gov – National Institute for Mental Health – valuable source of information on a wide variety of topics associated with mental health.

www.mentalhealth.org.uk – Mental Health Foundation – includes a section dedicated to issues concerning young people, including a page of selected international news.

www.mind.org.uk – Mind – offers access to leaflets, information, routes to legal advice as well as a telephone helpline.

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This Briefing has been independently and anonymously reviewed by an academic and a practitioner with special interest in services in child and adolescent mental health problems. For a fully referenced version, visit the **research in practice** website:

www.rip.org.uk/mainmenu.html?publications/qpb/index.html

