CHILDREN'S MENTAL HEALTH & EMOTIONAL WELL-BEING IN PRIMARY SCHOOLS

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MENTAL HEALTH AND EMOTIONAL WELL-BEING

Chapter objectives

By the end of this chapter you should be aware of:

- what we mean by 'whole school approach' in relation to the chapter;
- common mental health problems affecting children and young people;
- origins and prevalence;
- curiosity about changes in children and young people's behaviour;
- how changes in behaviour may be about a potential emerging mental health problem;
- the importance of getting a balance of not always pathologising children and young people's behaviour;
- how some presenting behaviours can be considered 'normal' when the context is understood, so the 'context' beyond the child may require attention;
- what contributes to poor mental health;
- treatments, interventions and therapeutic approaches;
- how schools can help.

Teachers' Standards

This chapter supports the development of the following Teachers' Standards:

TS8: Fulfil wider professional responsibilities

- Take responsibility for improving teaching through appropriate professional development, responding to advice and feedback from colleagues.
- Communicate effectively with parents with regard to pupils' achievements and well-being.

Introduction

The chapter will consider aspects of child and adolescent mental health with a brief overview of the most common presenting problems, together with consideration of the role schools, teaching and educational staff can play. Other important considerations in relation to child and adolescent mental health such as risk and resilience are explored in Chapter 4.

The 'No Health Without Mental Health' strategy (DoH, 2011) cited that over half of lifetime mental health problems begin to emerge by age 14, and three-quarters by the time people reach their mid-20s. Mental ill health really is a disease of the young at what should be an optimum time of life. These children and young people are often in our schools when their mental health problems are emerging. Mental health is the foundation of healthy development. Having mental health problems early in life can have adverse and long-lasting effects (Murphy and Fonagy, 2012). Teaching staff and other school staff are the professionals spending the most time with children and young people, more than any other professional group, and are well placed to notice any behaviour changes which may indicate a problem (Weare, 2015). School is a major part of children and young people's lives, as over a third of their time is spent in school – meeting and making friends there and with teaching staff playing a large part in their development (Royal College of Psychiatrists, 2016, p11). We have a 'window of opportunity' because of the progressing and continuing developmental aspects, unique to children and young people, for offering early help and support so that lifelong outcomes can be improved.

The Pursuit of Happiness report (CentreForum Commission, 2014, p36) and the House of Commons Health Committee (2014) recommends that teaching and educational staff should receive training in child development, mental health and psychological resilience so that vulnerable children can be identified. The CentreForum Commission recognised teachers are not mental health professionals but that they should have skills of recognition and know how to access help and when to refer to CAMHS. Other recommendations in the report include a requirement for the national curriculum to include teaching on children and young people's mental health and improving their resilience. The topic of child and adolescent mental health is now frequently featured in the media, and is the subject of frequent political debate. The most recent reports and events include 'Future in Mind: Promoting, protecting and improving our children and young people's mental health and well-being' (DoH, 2015). 'Future in Mind' is the findings and recommendations of the Children and Young People's Mental Health and Wellbeing Taskforce. It firmly sets a whole child and whole family approach, promoting good mental health at the earliest ages, and moving away from only thinking about mental health from a clinical position. It acknowledges the role schools are already playing in supporting pupil mental health and that this needs to be further developed by earlier identification of issues and early support.

Teaching children and young people how to improve their resilience should be a whole school approach with the promotion of emotional health and well-being embedded into the culture and core business of school settings. The report recommends promoting the emotional well-being of the whole school community, noted as very important given that educational staff have high rates of work related stress (CentreForum Commission, 2014, pp32–33; Weare, 2015). The MindEd e-portal was introduced in 2014 as an online electronic resource for professionals interested in child and adolescent mental health and provides clear guidance on children and young people's mental health,

well-being and development. In 2017, Prime Minister Theresa May announced a commitment to improve mental health and well-being including Mental Health First Aid training for all secondary school staff with an additional emphasis on improving mental health in the workplace for staff (BACP, 2017).

Prevalence

The National Service Framework for Children, Young People and Maternity Services (2004) identified that 10 per cent of 5–15 year olds had a diagnosable mental health disorder. That is equivalent to an average of three children in every classroom in every school in Britain. A further 15 per cent have less severe problems and remain at an increased risk of future mental health problems (Brown et al., 2012, cited in Department for Education, 2015, p34). 'Future in Mind' (DoH, 2015) acknowledged that 1 in 10 children needs support for mental health problems. These figures are based on the B-CAMHS survey last commissioned and published over 13 years ago in 2004. There has been no full scale study since then. This has been criticised as now being long overdue by the Royal College of Paediatrics and Child Health (2014). Previously the study had been conducted every five years so there is now a lack of reliable up-to-date data (House of Commons Health Committee, 2014). Under 5s were not included in the 2004 survey despite the evidence for the importance of the early years as an opportunity for intervention. Research has suggested that between 50–60 per cent of children showing high levels of disruptive behaviour at 3–4 will continue to have these problems at school age (Murphy and Fonagy, 2012).

Understanding mental health in children and young people

Many mental health problems have their origins in childhood (Dogra et al., 2009). An accepted view is that mental health and ill health arises from a context of variables including biological factors such as genetics and brain development, and psychological variables that include coping mechanisms and how these then interact in relation to either adverse or positive environmental circumstances or experiences. Another way to consider this is that early experiences also impact on brain development, and it is the impact of these experiences on inherent temperament and character that psychological development therefore becomes influenced. An individual's inherent genes can be triggered by experiences in childhood. It is also important to consider and be mindful that most presenting mental health conditions are medicalised and are an interpretation of behaviours considered to be beyond what would be accepted as normal behaviour. But these can also be thought about from a psychological perspective. Often children and young people are 'acting out'. Acting out is a defence mechanism and defends the individual from anxiety and is an emotional and externally visible response to overwhelming and unmanageable feelings (Burton et al., 2014). It is important to try and understand the behaviour within the young person's context.

In relation to poor behaviour, approaches based on punishment focus on the negative and tend to be very common. For example practices such as writing the offending child's name on the classroom board for the day or withholding playtime in younger children do not get to the bottom of

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the problem. It is not helpful to come from a position that sees poor behaviour as intentional or under the child's control; bear in mind that usually it is not. Try and see the whole child behind the behaviour and instead of focusing on negatives, focus on positive characteristics (as discussed in Chapter 4) (Weare, 2015, p11). Incidentally, play is a right under Article 31 of the United Nations Convention on the Rights of the Child (1989) so there is really no case for withholding/rewarding using play in this way.

Very often, behaviours can be understood within their context and may be temporary and a reaction to adversity. For example a child may become anxious and not want to leave a parent and go to school. But if there are changed family circumstances such as bereavement, domestic abuse, or parental mental or physical illness this could explain the changed behaviour. That is not to say a clinical judgement is not required if a child is highly anxious or likely to be depressed, as it would be important to do so in order to access appropriate treatment. Using the term 'mental disorder' or 'problem' indicates that the issue resides within the child, and is not always helpful, but problems or disorders can develop as a reaction to external circumstances as shown by the case studies (Murphy and Fonagy, 2012). Similarly a diagnosis of 'attachment disorder' implies that there is something inherently wrong with the child. The reason a child has not been able to develop appropriate attachment, however, is a direct reflection of the impact of the adults'/primary caregivers' caring of the child (Dogra, 2011). One of the most important things to remember is when a change of behaviour is observed, be curious and explore what may be happening in the child or young person's context. We often make the mistake of expecting children and young people to 'behave' within what is considered 'normal' in the class and school settings but that can sometimes be an impossible task for a young person struggling to deal with any problems they may have or have encountered. If they feel misunderstood, criticised and ultimately unsafe it is likely to make things much worse for them.

Typical mental health problems in children and young people

Children and young people can experience the same mental health problems as adults. The difference between adults and children, which is important to understand, is the requirement to think about these presentations within the context of the developmental phase.

There is a considerable overlap across the range of problems and conditions, with an emotional element consistently present throughout. Some children may have both physical illness, with mental health problems or disorders as a combination or 'comorbidity'. For example, a young person with diabetes may place themselves at risk through non-compliance with diet and medication, which could be considered an aspect of self-harming behaviour. Overall children with mental health problems are also at increased risk of physical health problems (DoH, 2015, p25).

Presentations need to be thought of in the context of normal development which is on a continuum of constant change. It is important to remember that risk-taking behaviours and mood changes would be considered normal adolescent behaviour. Physical and hormonal changes leave the adolescent brain less able to regulate emotion and impulse (Weare, 2015). Not only do any potential symptoms need to be considered from a developmental perspective but also within the context of

the child or young person and their experiences; therefore, what *is* and what *ha*s been happening (Burton et al., 2014).

The most common mental health problems for children and young people are depression, anxiety, conduct disorders, attention deficit hyperactivity disorder (ADHD), and autistic spectrum conditions (ASC) (Murphy and Fonagy, 2012). Other significant mental health conditions include: eating disorders such as anorexia nervosa, attachment disorder, post-traumatic stress disorder, self-harm, suicidal behaviours, mood changes, behaviour changes, relationship and attachment difficulties, substance misuse, changed eating patterns, isolation and social withdrawal and somatic problems. Somatising features and problems (physical symptoms with psychological origins) include, for example: headaches, enuresis and encopresis (faecal soiling), tummy aches and sleep disturbances, often present in younger children and can be fairly common with varying degrees of severity, frequency and persistence.

Depression

Depression is now recognised as a major public health problem in the UK and worldwide. It accounts for 15 per cent of all disability in high-income countries. In England, 1 in 6 adults and 1 in 20 children and young people at any one time are affected by depression and related conditions, such as anxiety. 0.9 per cent of children and young people are seriously depressed (DoH, 2015). According to the International Classification of Diseases (ICD-10) (World Health Organisation, 2010) and the Diagnostic Statistical Manual (DSM-5) (American Psychiatric Association, 2013), depression is characterised by an episodic disorder of varying degrees of severity characterised by depressed mood and loss of enjoyment persisting for several weeks. There must also be a presence of other symptoms including: depressive thinking; pessimism about future, suicidal ideas; and biological symptoms such as early waking, weight loss and reduced appetite (NICE, 2013a).

The criteria are similar for children and adults but with important differences (Keenan and Evans, 2009). With children and young people, developmental perspectives and context are highly relevant, as already discussed. For example, eating and sleeping disturbances often present as potential symptoms, but these would be common in childhood anyway. Tearfulness and crying has a very different meaning and incidence in childhood compared with adulthood. It is not uncommon to feel depressed at times. It is also important to 'normalise' sadness as a passing human condition. If sadness became persistent over time this would be different and a cause for concern (Burton et al., 2014).

Anxiety

Anxiety, it must be remembered, is normal. Anxiety becomes pathological when the fear is out of proportion to the context of the life situation and, in childhood, when it is out of keeping with the expected behaviour for the developmental stage of the child (Lask, 2003). It is also one of the most common mental health problems with an estimated 300,000 young people or 3.3 per cent in Britain having an anxiety disorder (Royal College of Psychiatrists, 2014; DoH, 2015). For example separation anxiety would be considered normal for infants (leaving a primary carer) but less so for a teenager. In a relatively short time span, in comparison to the full length of human life,

children move from a state of limited emotional understanding to becoming complex individuals. The number and complexity of emotional experiences together with modulation of human expression increase with age. It is therefore not surprising that some children and young people are easily overwhelmed and experience emotional disorders, which if they persist are debilitating and require intervention and help. There are many variations of anxiety and children can experience anxiety in some of the following ways: worries, phobias, separation anxiety, panic disorder, post-traumatic stress disorder and obsessive compulsive disorder. Thinking about the above variations in how anxiety is expressed it is useful to consider a developmental perspective – there are different fears for different years. In infancy if secure attachment is accomplished, fear of separation from a caregiver diminishes. Separation anxiety usually begins in the pre-school years any time after the attachment period but typically in late childhood, early adolescence. Other fears, such as fear of the dark, can appear, and then, as the imagination develops, ghosts and monsters. Animal phobias, such as a fear of spiders or dogs, usually begin in childhood. Performance anxiety can emerge in late childhood and social anxiety in adolescence. Fears and anxieties are normal developmental challenges facing the maturing individual. During adolescence, autonomy and independence are major developmental challenges, endeavouring to balance between compliance with rules and expressing independent autonomy. It is normal to experience conflict to some level, but the challenge posed by emerging autonomy can trigger or exacerbate interpersonal problems that require negotiation with the accompanying anxiety (Burton et al., 2014; Royal College of Psychiatrists, 2014; Young Minds, 2016).

Conduct disorders

5.8 per cent of children and young people have a conduct disorder (DoH, 2015).

> *Conduct disorders nearly always have a significant impact on functioning and quality of life. The 1999 ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three to fourfold increase in prevalence in social classes D and E compared with social class A. The 2004 survey found that almost 40 per cent of looked-after children, those who had been abused and those on child protection or safeguarding registers had a conduct disorder.*

(NICE, 2013b, p4)

Conduct disorder refers to aggressive, destructive and disruptive behaviours in childhood that are serious and likely to impair a child's development. In DSM-5 there is a distinction between oppositional defiant disorder (characterised by recurrent negativistic, defiant, disobedient and hostile behaviours) and conduct disorder, which includes a presence of repetitive persistent violations of societal norms and other people's basic rights. In ICD-10 oppositional and conduct problems are both included under the heading of conduct disorder. Many behaviours included in the diagnosis are common in normal child development, but when they are persistent and frequent they bring increased risks in later life including: anti-social behaviours, a range of psychiatric disorders, educational and work failure and relationship difficulties (Moffitt et al., 2002). Conduct disorder is more common in boys than girls (NICE, 2013b). There is frequently co-morbidity with other illness including substance misuse, anxiety and ADHD. It is considered there is substantial heritability but little is known about the mechanisms. Individual risk factors include low school achievement and

impulsiveness; family risk factors include parental contact with the criminal justice system and child abuse; social risk factors include low family income and little education (NICE, 2013b).

Parenting practices in families of conduct-disordered children are reported as often hostile and critical, with harsh discipline, a lack of consistent rules, low monitoring of behaviours and parental disagreements. Un-cooperative behaviour and aggression is frequently cited as a reason for school exclusion. Often, these sorts of behavioural problems can be linked to communication difficulties. A research study by Gilmour et al. (2004) found that pragmatic difficulties underlie anti-social behaviour in a proportion of children diagnosed with conduct disorder. Many have deficits in pragmatic language skills in a similar way to children on the autistic spectrum. Significant numbers of children with autistic spectrum disorders remain undetected. The research further cited that children with such deficits do not tend to use language in a way that takes account of a social hierarchy (peer, teaching assistant, head teacher), and are unaware of the adverse consequences.

Where there is a combination of inherited vulnerability plus negative parenting, especially early negative affect and intrusive control, these factors contribute to the development and persistence of conduct problems. These are often highly vulnerable young people and can be at risk to themselves and others (Burton et al., 2014).

Attention deficit hyperactivity disorder (ADHD)

1.5 per cent of children and young people have severe ADHD (DoH, 2015). Characteristics of ADHD include a triad or constellation of impairments in the following three areas:

- Poor concentration.

- Hyperactivity.

- Impulsiveness.

It is important to recognise that displaying the above behaviours does not necessarily mean ADHD is the explanation. These behaviours may indicate psychological causes. Think about how you might behave if you were in a stressful situation, experiencing stress and anxiety – all of the above areas are likely to show changes. A key factor is the persistence and frequency in all domains (Burton et al., 2014).

A problem for children and young people is that their ADHD impairments can impact significantly on educational experiences and attainment. Young people with ADHD have a higher rate of behavioural and disruptive disorders and are disproportionately represented in the youth justice service. Children with ADHD struggle to regulate activity and they are not able to evaluate their responses beforehand or subsequently. Exhortations often made of them to 'try harder' or 'learn to concentrate' are impossible to fulfil, are unhelpful and tend to reinforce failure.

The range of possible lifetime impairment extends to educational and occupational underachievement, dangerous driving, difficulties in carrying out daily activities such as shopping and organising household tasks, in making and keeping friends, in intimate relationships (for example, excessive disagreement) and with childcare (NICE, 2008, p5).

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As with other disorders ADHD is classified in both ICD-10 (hyperkinetic disorder) and in DSM-5. Severe ADHD corresponds approximately to the ICD-10 diagnosis of hyperkinetic disorder. This is defined as when hyperactivity, impulsivity and inattention are all present in multiple settings, and when impairment affects multiple domains in multiple settings. Part of the assessment process would include collecting information from parents and from educational settings. Diagnosis is a matter of clinical judgement which considers the severity of impairment, pervasiveness, individual factors and familial and social context (NICE, 2008).

There are strong genetic influences and often history-taking reveals other family members exhibiting ADHD traits that are undiagnosed; this is significantly so in earlier generations where ADHD was unrecognised. No single gene has yet been identified. Environmental factors include maternal drug and alcohol use in pregnancy. In addition, ongoing effects of individual and parental substance misuse, poor or hostile parenting also needs to be considered. In the UK, a survey of 10,438 children between the ages of 5 and 15 years found that 3.62 per cent of boys and 0.85 per cent of girls had ADHD (Ford et al., 2003). ADHD seems to be approximately four times more common in boys than girls.

It can be helpful to re-frame the negative symptoms of ADHD in terms of positive aspects. It is not always helpful to focus on reducing 'unwanted' behaviours; alternatively it is better to harness the positives (as discussed in Chapter 4). There is potential for these young people as they usually have energy and enthusiasm by the bucket load. They have a 'feet first' activist approach, which during childhood and adolescence can get you into trouble but needs to be seen as also having advantages. It can be difficult to 'fit in' to 'systems', however, especially the demands of education, which can be stacked against a child or young person with ADHD (Burton et al., 2014).

Autistic spectrum conditions (ASC)

Autism in Britain was first labelled as childhood psychosis at the beginning of the twentieth century. In 1944 it was named 'Kanners Syndrome', and then in the latter part of the twentieth century 'Autism' (Wing, 1996). Asperger's Syndrome was identified in 1944 although it took until 1979 for Asperger's work to be translated from German to English. It wasn't until 1991 that the term Asperger's Syndrome was recognised in Britain. The difference between autism and Asperger's syndrome is that 'Aspies' are of average or higher intelligence and develop language skills in the normal developmental way; the reverse is true for autistic people (Bradshaw, 2013, p55).

Autistic spectrum conditions or disorders form a very broad variation in presentation. 'Spectrum' indicates that while sharing the same condition there is a wide range of difficulties experienced in different ways. On a scale of 0–100 on the spectrum, a social and communicative person would appear at the starting point of the scale, zero. Moving further along the spectrum someone with a few autistic traits, such as a need for routine, would appear. The stronger the autistic traits the further along the spectrum, so at 100 there would be a person with no speech and limited responses to others (Muggleton, 2012, p31). There may also be accompanying learning disabilities. It is a lifelong condition and, unlike all the other conditions discussed in this chapter, it has a biological origin and is a disorder of development. In addition, it is also important to remember that autistic children, young people and adults often experience sensitivity to sounds, touch, tastes, smells, light or colours (The National Autistic Society, 2013).

Autism is characterised by a triad of features related to impairments of functioning in:

- social communication;

- social understanding;

- social imagination and play.

There are also accompanying and ritualistic stereotyped interests and behaviours. These are usually evident from infancy although they may not be recognised at that point. Play is often a pre-occupation with repetitive activities.

Again, as with children and young people with ADHD, it is helpful to consider positives for Asperger's children. Having a diagnosis does not in itself change anything but it can help parents and teachers to understand a child's needs and put in place supportive measures. Strengths can be in individual sports, for example. Another trait is honesty; never ask 'how do I look?' If you are not prepared for an honest response, do not ask if the truth is going to hurt! Similarly language needs to be straightforward; if you ask a young person with Aspergers (often referred to as 'Aspie') to 'hold your horses', i.e. slow down, or say 'it's raining cats and dogs', you will have a puzzled response wondering where exactly the horses, cats and dogs are.

Eating disorders

Eating disorders can develop in childhood or adolescence in keeping with other mental health disorders, becoming most frequent with an age of onset of between 15–35 years. Anorexia nervosa has a mortality rate which is twice the level of any other illness and has the highest death rate of any mental illness (Treasure and Alexander, 2013). Anorexia has always been considered a predominantly female disorder, borne out by the statistics; nevertheless, professionals also need to be mindful of the fact that boys and young men do develop anorexia. It is generally considered that eating disorders, as with other psychological disorders and mental illnesses, arise from a combination of biological/medical, psychological and social or environmental factors as discussed above. It is the articulation and inter-relation of these overlapping theories, together with risk and resilience factors, as a combination, which leads to understanding and interpreting the causes of eating disorders, and not a single application of a model (Burton, 2014). However, the case for being driven predominantly by the medical genetic origin is quite strong. More recent research suggests a strong genetic link and pre-disposition, and demonstrates that anorexia nervosa is not a lifestyle choice but rather an inherent gene which is most probably present and becomes vulnerable when exposed to other factors (Lask et al., 2012). Other factors would include psychological attributes with perfectionism implicated as both a risk and a maintaining factor (Fairburn, 2003; Wade and Tiggeman, 2013). Typically, young people with anorexia often have 'perfectionist' traits and can be academically high achievers. But they often have low self-esteem and find it difficult to express or externalise negative emotions (Dhakras, 2005). Media and societal attitudes towards thinness are often cited as 'reasons' but they are not reasons in isolation, and can act as contributing factors or triggers. Other pre-disposing factors centre on the negotiation of transitional points, for example the negotiation of adolescence in combination with an adverse life event such as bereavement, parental divorce or sexual abuse, together with an inherent psychological vulnerability (Burton, 2014).

Self-harm and suicidal behaviour

Self-harm and suicidal behaviour are emotional disorders on a similar continuum as they are both in response to stress. Self-harm tends to be about coping whereas suicidal behaviour can be associated with giving up or seen as a solution to overwhelming and intolerable feelings but not necessarily about wanting to die. Young people who self-harm are at a higher risk of suicide. The Royal College of Psychiatrists report (2014) highlighted the fact that patterns of self-harm are evolving with the explosion of digital communication. Unfortunately, self-harm is frequently stigmatised with individuals being described as 'attention-seeking'. This is unhelpful and it is important to maintain curiosity over why the young person may be expressing their feelings in such a way in order to be able to offer appropriate support. It is important to assess all episodes of self-harm individually in a person-centred and systemic way, as failure to do so can lead to individuals feeling misunderstood (NICE, 2004). If it remains hidden it can lead to guilt and shame which is often compounded by the negative reactions of others (Nixon, 2011). Young people are vulnerable to suicidal feelings. The risk is greater when they have mental health problems or behavioural disorders, misuse substances, or have family breakdown or mental health problems or suicide in the family (DoH, 2011). Adolescence is the most turbulent developmental period since infancy with the biggest challenges and changes in all areas of biological, psychological and social change. Pre-disposing vulnerabilities such as poor or adverse early experiences can be activated during the adolescent phase (Anderson, 2008). Triggers influencing self-harm and suicidal behaviour include: bullying, difficulties with parental and peer relationships, bereavement, earlier abusive experiences, difficulties with sexuality, problems with ethnicity, culture, religion, substance misuse and low self-esteem. Contextual triggers include adverse family circumstances, dysfunctional relationships, domestic violence, poverty, parental criminality, time in local authority care, frequent punishments and family transitions. All of the above become compounded by adolescent developmental pathology (Harrington, 2003).

Bell (2000) describes how the cause given is actually the trigger precipitating suicidal behaviour, but it will often be the reason given by the young person, their families, and even doctors and other clinical staff. Reasons given might include an argument with a close friend or family member, or failing exams. The notion of a trigger as an explanation often leads to a minimising of the level of seriousness surrounding the suicide attempt which is *never* about the stated reason. Rather, it is a rationalisation of the event rather than an explanation as it may be a frightening prospect for all concerned to consider serious mental disturbance. This is a very important point to bear in mind and is the key to understanding suicidal ideation. For example not all individuals who have arguments and fail exams make attempts on their lives, therefore those that do so for those reasons given are responding to a trigger (the argument, exam failure) to much deeper intolerable problems.

Suicide and suicidal ideation always takes place within the context of relationships which is the important challenge to explore and understand. Usage of triggers as an explanation can lead to collusion and denial of the seriousness of the event, not only by family members but clinical staff also, and therefore it is highly risky in itself not to take the attempt seriously. Suicide attempts should be taken seriously and must never be minimised by describing somewhat trivial reasons such as relationship disagreements or exam failure which are in fact the precipitating triggers (Burton, 2014). The difference in self-harming behaviour, as opposed to an intention to kill oneself, is that with

self-harm the person is in touch with their body through the physical reality of pain. The skin becomes a medium for communication (Gardner, 2001). Physical pain is often easier to manage than emotional pain which, when inflicted, can change mood, which, in turn, can be habit-forming. Cutting releases endorphins into the system, providing a brief calming effect, combined with serotonin as a mood enhancer. It can therefore be seen as a form of relief. There can also be something about experiencing first aid 'patching up' and 'repairing' either by the individual or helpers, with these repairing acts experienced as therapeutic.

KEY REFLECTIONS

- It is estimated that three children in every classroom have a diagnosable mental health condition; these figures are based on research now over 12 years old. These statistics are not expected to have reversed.
- Half of lifetime mental health problems (excluding dementia) begin to emerge by age 14 and three-quarters by the mid-20s.
- Mental ill health arises from a context of variables: genetic biological factors (bio-medical) and psychological factors and how these articulate with lived experiences (psychosocial).
- When considering children and young people, potential symptoms need to be assessed from a developmental and contextual perspective; for example 'risk-taking' behaviour could be considered part of adolescent pathology and therefore normal.
- Children and young people can experience the same mental health problems as adults.

Interventions, strategies and therapeutic treatment approaches: how can schools help?

The Annual Report of the Chief Medical Officer 2012, *Our Children Deserve Better: Prevention Pays*, included a key message that service design should recognise the role, importance and potential of schools in fostering the development of resilience and opportunities for delivering interventions that can improve mental health (Murphy and Fonagy, 2012, p12). Child and adolescent mental health sits within a medical and psychological diagnostic model. Children and young people, as already identified, tend to receive a diagnosis if an assessment reveals this to be appropriate. This will be a primarily medical interpretation but the approach both to interpretation and treatment is one which considers all factors, including psychological and sociological. An appropriate treatment or intervention is then recommended according to the diagnosis. Freeth (2007, as cited in Prever, 2010, p57) argues that this model does not sit well with the 'person-centred' approach, although CAMHS workers do adopt a 'person-centred' approach where the focus is on relationship-building alongside the treatment or intervention. Regardless of what sort of approach is used, cognitive behavioural therapy, solution focused therapy, eye movement de-sensitisation re-processing (which is receiving more attention for the treatment of post-traumatic stress disorder in CAMHS

(NICE 2005; Tufnell, 2005)) or family therapy and family work, the point is not to primarily pathologise an individual according to a diagnosis, but to adopt a person-centred relationship approach.

The person-centred approach is the most widely known of the humanistic approaches developed by Carl Rogers in the 1950s. Rogers' core conditions of empathy, unconditional positive regard and congruence tend to underpin all approaches of therapy and are the mainstay of the therapeutic relationship and effective communication (Rogers, 1957). In CAMHS, as discussed previously, a person-centred approach also considers the child and young person in relation to their context of family. Similarly for teaching staff it is essential to consider the child or young person's context in order to assist with understanding of what may be happening. Whilst doing so it is very important to remain 'child-focused' and to be in a position that maintains and supports the child or young person from an appropriately developmental position. Whilst the family can sometimes be seen as part of the problem, it is important to avoid a blaming stance and to also see the family as a resource for change.

Interventions and therapeutic approaches in CAMHS Tiers Two–Four usually include: play therapy, art therapy, parent–infant psychotherapy, under-5s work, cognitive behaviour therapy, individual work, family work, parenting work and family therapy. There will often be a combination model of a psychological and pharmacological intervention and approaches as shown in the case studies below.

For conduct disorder, multi-dimensional treatment can include parent work and individual work. Psychosocial therapies are the main approach to conduct disorders involving close working with parents through parenting programmes and parent–child interaction therapy with the key feature being positive parenting (Murphy and Fonagy, 2012). It can be combined with risperidone (pharmacological approach) for a short period alongside other approaches as above (NICE, 2013b).

Treatment approaches for ADHD include a pharmacological approach as first line treatment (in conjunction with parenting and individual programmes) for ADHD using a prescribed psychostimulant (methylphenidate) (NICE, 2008). Medication can help children with concentration so has a valid use in supporting children in school settings. It can buy *thinking time* so impulsivity is reduced, and that does help significantly with concentration. It can help with symptom (triad of impairments) control, and does not remain in the system for more than a few hours. Treatment 'holidays' can be taken, so for example, the young person may not need to take medication at the weekend or in the school holidays. Management of ADHD includes parent and teacher training in behavioural techniques as well as individual support for the young person. A multi-faceted and multi-agency approach in the management of ADHD includes teacher training in behavioural techniques. There are, however, side effects including loss of appetite and difficulty getting to sleep (Burton et al., 2014).

In schools there is an emerging and promising evidence base for mindfulness, not just for children but also school staff. It provides an opportunity for implementation, adoption and embedding into the curriculum as part of a whole school approach to emotional health and well-being (Weare, 2015; CentreForum Commission, 2014). Other whole school approaches include 'circle time' for younger children. In addition, nurture groups, peer mentoring and buddy systems offer important

opportunities to build on children and young people's resilience factors and therefore mitigate risk factors as discussed in Chapter 4.

Strategies for improving the mental health of children and young people can operate at multiple levels. A goal for teaching and school staff is to develop relationships and partnerships with local agencies who can provide specialist support through service partnerships. But it is recognised that this is against a backdrop of reductions in CAMHS budgets, mainly in the Tier One and Two early intervention services. This has led to higher thresholds for referrals to CAMHS, leaving children, young people and families not able to access services until their problem is severe. It is interesting to consider this would be completely unacceptable for childhood cancer services (CentreForum Commission, 2014, p34). An increase in the tiny 6 per cent CAMHS budget of the overall mental health budget is long overdue (House of Commons Health Committee, 2014, points 80 and 86). Some of the most effective school interventions have proved to be targeted mental health services (TaMHS) where early identification and support prevents problems escalating. Weare (2015) noted that often schools wait too long, not wishing to 'label' and often thinking children will 'grow out' of problems. Where possible working with local agencies and CAMHS brings education and health together to think about children and young people where and as soon as concerns are raised.

KEY REFLECTIONS

- Schools have potential and opportunities to mitigate children's mental health through whole school approaches being embedded into the curriculum. Examples of these include mindfulness, nurture groups, buddy and peer mentoring systems.
- It is essential to consider the child's context as this contributes to understanding.
- There are multiple treatment approaches including psychological and pharmacological support.
- Many approaches are primarily about working with parents.
- Try to make links with professionals in CAMHS for joined up working and wrap around support.

CASE STUDY: JOE

Joe has a diagnosis of ADHD. He is easily distracted and finds it difficult to concentrate for very long and is sometimes impulsive.

Joe is 7 and in a primary school class with 20 other boys and girls. The classroom is sunny and bright, with equipment, bookshelves and storage boxes all around the room. There are posters and pictures on the walls. The teacher has a whiteboard. All the children sit at tables which join each other in a group. There are 4 children to each group of tables. They are facing each other and not the teacher who is standing at the front of the class. There is a teaching assistant helping Joe with his task. Joe is colouring in letter shapes and then cutting them out to stick on a poster. While he

is colouring he keeps looking around the classroom and shouts over to his friend on another table who waves back. Joe starts talking to the boy opposite him. The other children round the table are busy working and cutting out. He is trying to concentrate but finds it difficult to stay on task. The teaching assistant reminds Joe to keep on colouring and then she helps him with the scissors and cutting out a letter R. Joe manages to cut out a letter L for which he receives praise. At the end of the lesson Joe receives a gold star for working hard. He rushes outside at break and tears round the playground with the other boys.
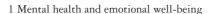
Case study reflections

- Consider classroom layouts; for children like Joe it can be harder to concentrate when he is facing other children, not the class teacher.
- Joe is having great support from the class TA.
- Joe is praised and rewarded for staying on task which will have been difficult for him.
- Playtime is a really important opportunity to let off steam and play before the next class.
- Sometimes children like Joe, who end up finding it difficult to concentrate and get into trouble, have play curtailed or minutes deducted. This is not helpful and is counter-productive.
- It can be helpful to reframe potential negative characteristics and focus on positive aspects of ADHD, as in higher energy levels and 'up for anything' traits.

Integrating psychological care into Tier One universal settings such as schools can work as a pre-ventative and protective strategy. School-based counselling is an available and accessible form of psychological therapy for young people in the UK, with approximately 70,000–90,000 young people accessing services per year (BACP, 2013). 'Future in Mind' (DoH, 2015) suggests a whole child and family approach with a move away from thinking purely clinically about child men-tal health with an emphasis on prevention, early intervention and recovery and that this needs to be considered and implemented universally across settings. The Pursuit of Happiness report (CentreForum, 2014, p36) recommends that for children with less severe and emerg-ing mental health problems, there should be greater accessibility to psychological therapies in schools and that the service could be provided by a practitioner with a CAMHS background. In secondary schools, young people should have routine access to a named CAMHS worker. School nurses can be an essential resource with a significant proportion of their workload consisting of supporting children and young people with emotional and psychological difficulties (Bohenkamp et al., 2015). They often, however, lack mental health training. This has been recognised by the Royal College of Nursing as an important issue and they have asked for country-wide standard-ised mental health training (Brown, 2015). School nurses are on the front line in terms of being a health professional accessible to young people in schools and are well placed to offer support and make links within their school community and staff and also with other professionals and CAMHS.

Counselling and psychotherapy for children and young people is very different from the traditional adult approaches and needs to be developmentally appropriate, individualised, flexible and creative. It needs to engage young people who are often reluctant to talk or find it difficult to recognise or understand their feelings. The young person's context or system also requires attention as they are

inter-related and one cannot function in isolation from the other. Children and young people are usually one part of a wider family and are often relatively powerless to change their situation unless their family are supportive of the changes. Typically, a young person may be receiving age-appropriate support individually but ideally, and if possible, this would also be alongside parent and family work (Burton et al., 2014).

CASE STUDY: SARAH-JANE (WITH THANKS TO DR CLARE SMITH)

Sarah-Jane is 5. She started in reception class in September and is one of the older children, having had her 5th birthday in late September. It is now mid-February and Sarah-Jane's teacher, Miss Jennings, is becoming increasingly worried as, although S-J's school attendance has been very poor since she began school, it is getting worse. S-J's attendance has averaged about 50 per cent since the start of term. Her mother is very good at letting school know when S-J is off by phoning in the morning when she's going to miss school and always sends a note when S-J goes back to school. The reasons she gives for keeping S-J off sound genuine, but just seem to be very frequent (cold, cough, earache, sore throat etc.). Miss Jennings is especially concerned that S-J, who has always been very quiet, has become almost silent. S-J seems very withdrawn and doesn't play much with other children at school. She is becoming harder and harder to engage, although she seems to be an exceptionally polite girl who appears keen to please. During the last week, S-J has cried frequently at school, often over little things.

S-J lives with her mother, father and younger sister who is 3. Mum used to be a librarian but did not return to work after having S-J. Dad works installing telephone networks and commutes by train into a nearby city, walking to the station each day – a total commute of about 1½ hours each way door to door. Sometimes he works away from home for a week at a time. The family moved to this town so as to be within walking distance of Mum's work and a bit nearer Dad's workplace to shorten his commute, a year or so before S-J was born. Both sets of grandparents live in the town where S-J's parents used to live, about three quarters of an hour drive away. All the grandparents work full time, so the family has very little grandparental support. S-J's mum has a driving licence but doesn't like to drive.

S-J is always immaculately dressed for school. Her mum walks her to and from school every day, with her little sister in the push chair. S-J's teacher has noted that Mum is very quiet and tends not to chat with the other mothers in the playground.

Case study reflections

- There were several external factors affecting S-J.
- Miss Jennings realised that S-J was becoming more and more anxious because she was getting behind at school (her projects weren't as good as the other children's because she wasn't there enough to get on with them) and this worried S-J.

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- She recognised that Mum was keeping S-J off because she (Mum) was anxious about sending S-J to school – and so not sending her – when she had even the slightest snuffle or hint of being even a tiny bit unwell.

- She realised that Mum's anxiety about S-J was partly because she had no local support networks and hadn't made friends amongst the other mothers, so was socially isolated.

- Miss Jennings discussed the situation with the other reception class teacher and made a plan to support the situation such as identifying a member of staff to support S-J to successfully integrate with her peers at playtime.

- They asked for Mum's help with hearing the children read in the 'other' reception class (not S-J's). They suggested she come into school whenever the 3-year-old was at nursery. They guessed that if Mum had a commitment to come into school then S-J would have to come into school, too, so she wouldn't miss as much school and would become more confident.

- The plan worked. Both S-J and her mother became more confident and their self-esteem grew. Both became less anxious. Mum helped more and more at school and started to talk a little with the other mothers in the playground.

CASE STUDY, DISRUPTIVE BEHAVIOUR EXAMPLE: JANEK (WITH THANKS TO DR CLARE SMITH)

Janek is 8. He is in Year 4 at a mainstream primary school. He lives with his mother, Ania, and his younger brother, Marius, who is 5. The family is Polish but have lived in the UK for about 7 years. They travel back to Poland every summer to see Ania's parents. Janek's and Marius's parents separated when the boys were 5 and 2 and they see their father, Osa, alternate weekends when they spend Sunday afternoon and have tea with him and his new partner, Lindsay (who is white British), who live in another town. Both boys seem to get on well with Dad and Lindsay and do lots of fun things with them, but get home very tired on Sunday night. They also behave quite aggressively both at home and at school on the Monday and Tuesday after the weekend when they've seen Dad.

Mum works part-time in a local greengrocer's and is able to drop the children off at school on her way to work and finishes work in time to collect them from the after-school club at 4.30 p.m. each day. She gets a discount on the fruit and vegetables in the store, so the children have a very healthy diet. Mum appears to be warm and caring. She has no problems with Janek's behaviour at home unless she tries to get him to do homework, which he resists strongly.

Janek has a large, red birthmark covering one cheek (called a port wine stain). The other children at school are used to it and don't comment on it or tease Janek about it.

Janek's teacher, Miss Freer, complains that Janek is very disruptive at school. He shouts out and disrupts the class, drawing attention to himself and making the other children laugh. This is

(Continued)

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especially problematic during literacy lessons or when the children have to settle down to their writing. Miss Freer feels that Janek does everything he can to avoid tasks that require prolonged writing.

When the class are doing PE or sport, Janek is able to focus well. He can be quite responsible in these settings and likes to help the teacher by carrying equipment etc. He thrives on the praise he receives for his efforts.

In the playground, Janek gets on well with his peers. He usually plays football at playtime with a large group of friends. He's a good, popular player who doesn't hog the ball and is able to set up others to score goals.

Janek got on well at Beavers but can be a bit disruptive at Cubs (which he has only just started), though he is fine when they are doing activities outside.

Case study reflections

- Avoidance of writing task.
- Tired and aggressive after seeing Dad.
- A bit disruptive at Cubs.

Summary

Janek is an 8-year-old Polish boy who displays disruptive avoidant behaviour when he has to undertake effortful writing tasks. When not faced with such tasks he can behave with maturity. He can also be a little disruptive at Cubs which might be related to his avoidance of writing or might be due to issues around his facial birthmark. He is good at sport and gets on well with his peers. He appears to be well supported by his parents, though he only sees his father fortnightly for a few hours. Janek and his brother also behave quite aggressively for about two days after seeing their father, which may be related to tiredness after a busy day or the change in routine/structure (safeguarding issues were ruled out in this case).

- Plan: Discuss with staff involved (such as teacher, SENCo) to seek their opinions and feedback on your thoughts.
- Consider, with them, whether further assessment of Janek's writing difficulty would be helpful at this stage. (Sensory/motor/coordination problem = occupational therapist. Cognitive problem, for example, possible dyslexia = SENCo or educational psychologist.)
- Discuss your thoughts with Janek, Mum (and Dad if possible) so as to develop a collaborative plan with them.
- Think about: Would Janek be happy to have some extra help with writing tasks? See someone to find out more (assessment)?
- Think about: Would Dad be happy to have the boys on a Saturday instead?
- Think about: How would Janek or Mum feel about talking to the Cub Scout leader about possible issues with Janek's birthmark or with tasks involving writing when he's at Cubs?

Whatever issues children and young people exhibit, what would seem vital is that all interested parties work together to support an individual's future mental health and well-being. This will be facilitated by a whole school approach to mental health and well-being which involves its leaders, the voice of the child, the school's learning environment, the expertise of the settings professionals and a strong partnership with individuals' parents, carers and outside agencies. Such an approach must be seen as a pro-active response to provide timely support to any mental health or well-being issues as they may arise. This may, in turn, lead to the promotion of a continual drive to promote resilience within the children and young people in schools.

KEY REFLECTIONS

- Why is it so important to be aware of the myriad of factors that influence an individual's mental health and well-being?
- How might common mental health problems originate, affect and manifest themselves in children and young people?
- Why is it important that professionals do not always pathologise children and young people's behaviour?
- How important is it to understand children and young people's context when thinking about their behaviour?
- How can treatments, interventions and therapeutic approaches help?
- What is the role and importance of schools in supporting the needs of children and young people who exhibit mental health and well-being issues?

CHAPTER SUMMARY

- Problems often start in response to external factors around the child and not from within the child.
- Acting out and unwanted behaviours can be a coping mechanism and a way of hiding the hurt.
- Where early help and recognition is available, very often at school, problems can be mitigated and outcomes improved.
- Any change in behaviour provides a clue something may not be quite right and should initiate curiosity and further exploration as seen from the case studies.
- It is really helpful for school staff to see beyond the behaviour at what may be driving it.
- Focusing on positive aspects is the way forward as focusing on negative aspects through punishment is often counterproductive.
- Ideally schools and health especially CAMHS, where they are involved, should be thinking and working together to improve children's mental health and well-being both with individual cases and as a whole school approach.

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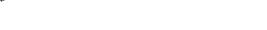
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