

RECENT DEVELOPMENTS IN CHILD AND ADOLESCENT MENTAL HEALTH

Report of a Centre for Social Policy Seminar

Dartington Hall, March 2015

The aim of the seminar was to review current mental health services for children and young people in the UK and to explore ways of improving them.

Introduction

Peter Wilson

Some thoughts on the meaning of child and adolescent mental health and on the history of services and current challenges facing their future development.

Peter Wilson, a child psychotherapist and former director of Young Minds, opened the seminar by explaining that he is finding the state of child and mental health services in the UK somewhat bleak. It is difficult to be positive about the current situation but he thought that by addressing the many challenges that face us, it might be more possible to think constructively and realistically about future developments

The 'problem' of young people's mental health is extremely broad and incorporates a very wide range of disorders and illnesses. But alongside developing services to treat these conditions is an equal need to promote health. This has been an encouraging message and the growing perception of mental health as a public health issue rather than a narrow psychiatric one should be welcomed.

But there are still difficult questions to answer and concepts to clarify. For example, what is mental health? What is the base line to compare normal with abnormal behaviour? Is the same behaviour interpreted differently in different contexts? Why is the focus on madness so attractive to the media? The book by Adam Phillips, *Going Sane*, is especially refreshing in this respect with its emphasis on sanity in relation to madness. As he put it, 'like the good characters in literature, the sane don't have the memorable lines'

Reports and research studies

The mental health of young people has rarely been off the scene in recent years and reports and research studies have regularly appeared. One of the first was the 1991 NHS thematic review, *Together We Stand*. This began with a definition of mental health, stressing the capacity to enter into and sustain mutually satisfying personal relationships, continuous and healthy psychological development (including age appropriate play and learning), and to develop a moral sense of right and wrong with the capacity to cope with stress within the limits of age and ability. Particularly important was the development of the

WHO's perspective that health cannot usefully be defined as 'merely the absence of illness or infirmity'. This vision implies that young people's mental health is the business of everyone – in communities, neighbourhoods, schools etc. - as well as health and social workers and is closely tied to the quality of life.

Zarrina Kurtz expanded this thinking in the report *With Help in Mind* which introduced the notion of undertaking a needs assessment within local communities as a basis for planning services. As a result of this report and *Together We Stand*, a tiered model of service provision was envisaged: Tier 1 promoting and preventing problems at a primary care level; Tier 2 offering specialist help in the community; Tier 3 delivering more intensive psychological and psychiatric interventions; and Tier 4 providing highly specialised residential and day provision. The vision comprised a broad comprehensive service rather than a solely a psychiatric one.

Informing all this discussion was emerging evidence on the prevalence of mental health problems among young people, the first of which was systematically gathered in the 1970s by Michael Rutter and colleagues on children living on the Isle of Wight. They concluded that 10% of the children showed significantly serious mental health problems; a level that people at the time found surprisingly high and difficult to digest.

Child Guidance clinics had, of course, since the 1920s laid the foundation for a multi-disciplinary model of service. They reached their heyday in the 1950s and 1960s. However, they tended to be small, poorly managed (with sometimes idiosyncratic styles of leadership) and took a fairly narrow view of mental health problems in the community.

The 1990s saw more reports and research studies, such as *Brighter Futures* (Mental Health Foundation), *The Health of the Nation Handbook* (Departments of Health and Education) and a *National Service Framework*. All of this encouraged a sense of optimism and growth.

The concept of mental health

Returning to the concept of mental health, several professionals around this time decided to adopt a fresh perspective and start not by looking at the problems but by asking fundamental questions about what children should be like. Qualities such as being competent, alert, sharing and generous, as well as a readiness to learn and communicate, are just some that can be prized as indications of mental health. In contrast, children without these qualities tend to be those who seem overwhelmed by their experiences, are overly fearful, angry and mistrustful, and withdraw and/or act out their distress.

Others writers and clinicians, such as Laing for example, were more radical and challenged orthodox psychiatry by viewing sanity as a form of complicity and madness as a response to the horrors of life, arguing that everyone may need at times some capacity to remove him or herself or to be depressed in the midst of distressing circumstances. Another group adopted an equally critical stance and

focused on children's identity and the importance of self-assertion and belief. They claimed that mental health consists of the strength to keep faith with one's 'true self' and to make a stand for what is felt to be right. The child with a so-called 'conduct disorder', for example, may be basically refusing to give up his protest at the maltreatment suffered. The gender 'disordered' child may be similarly refusing to relinquish an inner conviction that he or she is of the opposite sex.

Where do we stand today?

So in this pot pourri of definitions and perspectives, where do we stand today? The 10% figure offered by Rutter seems to be consistent in that it has been replicated by further research, not least by the ONS. There is also evidence that the range of problems is expanding to include ever more complex taxonomies of disorders and symptoms. Moreover, recent research (for example, Campion, Bhugra, Baily and Mormot, 2013) shows that half of lifetime disorders start before the age of 14 and 75% by mid 20s. The worrying fact is that we are nowhere near listening to the full extent and nature of the mental health problems of young people or meeting their needs and this failure is likely to show up later in life in such states as criminality, unwanted pregnancy, domestic violence and homelessness.

What can we do about it?

It is significant that this very week the Times newspaper has launched a campaign backed by ten manifesto points to improve children's mental health care. The deputy Prime Minister, Nick Clegg, has promised more money for services should his party remain in government after May.

The ten points in the action programme echo the recommendations of the earlier reports but are worth reiterating because they form a coherent strategy for reform. They are: undertaking prevalence studies every five years, equity of physical and mental health service provision, early intervention, more in-patient facilities, reduced waiting times, assessments of local need by CAMHS, service continuity up to the age of 25, training for tier 1 workers, the inclusion of a mental health module in teacher training and avoidance of dysfunctional policy swings and funding fluctuations.

There is also increasingly sound evidence on the causes of and solutions to many mental health issues, such as the findings emerging in neuroscience that indicate that children's brains are more flexible and responsive to environmental forces than was previously thought. There is also greater awareness of the role of schools in promoting mental health and the need for teachers to be more aware of the issues and ways of responding to them.

But two major challenges remain. The first has to do with the fact that we only know a fraction of the total picture about brain development, the influence of genetics and the significance of environmental factors, not least the new impact of the social media on young minds.

The second concerns the need for the range of professionals, practitioners and other concerned adults to come together to provide a comprehensive service for children in each locality. This is not easy, not least because of very poor funding. Mental illness accounts for 23% of the 'total burden of disease' yet it receives 13% of NHS expenditure (The Centre for Economic Performance Mental Health Policy Group, 2012). And only 6% of current spending on mental health goes to services aimed at children and young people (Kennedy). Moreover, funding cuts as drastic as 75% in some areas have eliminated the possibility of many interventions, especially those at Tier 3 level. A problem exacerbating this is the poor transitional arrangements and weak linkages between child and adult services and the artificiality of transfer at the age of 18. This division is deeply entrenched in the service structure despite being an age when many mental health problems escalate.

The possibility of overcoming these challenges is also weakened by other changes occurring in the system. One of these is the new arrangement for commissioning and the introduction of social markets. Commissioners have less and less money to spend but still have a lot of power. In response, a whole network of agencies, many of which are private, have set themselves up as potential providers. This has led to an industry of tendering and bidding and drawn out negotiations between people who have little experience of the problems and a limited understanding of cost-benefit analyses. Because of this, commissioners tend to follow NICE guidelines which basically recommend short-term cognitive behavior therapy for almost everything. This has had harmful consequences. It has led to a down-grading or making redundant highly qualified child, family and art therapists, allowed cheaper novices instead to practice, lowered the quality of therapeutic work, dismantled professional training and diminished the capacity of CAMHS to help anyone presenting problems that fall below a high threshold for seriousness. Consequently, morale, recruitment and the public image of CAMHS have been damaged.

There is also a current obsession with 'evidence based practice' that has become a key demand among commissioners. It is not a question of doubting the importance of evidence on the effects of interventions – this is essential for moral as well as economic reasons – but there is a problem when scientists are deified and assumptions made about the 'sureness' of their findings. Most research studies make recommendations but through closer scrutiny it is clear that they all face major methodological difficulties. Small or selective samples, failure to take account comorbidity and the use of non-professional volunteers are but just a few of the difficulties that are encountered. The lauding of CBT by NICE (to the exclusion other therapies) is highly questionable and potentially disastrous for services for the more complex child and adolescent mental disorders and, ultimately, for many of the children and their families.

These changes have also had a negative effect on the academic underpinning of mental health work. The use of classifications to help understand the nature of problems has diminished, the difficulty of using positivist research methods to evaluate interventions like psychotherapy has been dismissed and certain

concepts have been applied loosely - one example being resilience which has come to mean grit or stiff-upper lip or simply a happy smile in the face of adversity rather than a deep rooted and complex psychological response to stress factors. 'Resilience' rhymes too readily with adult 'convenience'

Finally, there is the interesting question of why public concern for mental health problems has changed since the optimism of *Every Child Matters* published 12 years ago. Obviously the economic downturn has been important but increasing individualism and narcissism, weaker community relationships, the idealisation or demonisation of children and, not least, the glamour of madness must also be held accountable.

Two case studies

There then followed two case studies to illustrate some of the issues raised in Peter Wilson's presentation. Flavia Ansaldo and Elspeth Pluckrose, child psychotherapists working with looked-after children in South London, presented with video clippings a case where smart phone technology was used to begin to regulate and express the unprocessed emotional states of a three-year-old boy who was becoming increasingly 'difficult to place'. The second used the film *Help Me Love my Baby*, produced by the Anna Freud Centre in London, to chart the year-long therapeutic experiences that helped a mother with post-natal depression overcome strong feelings of rejection towards her new born baby (who she was convinced hated her) and bond effectively with her growing child.

Both of these presentations vividly illustrated the importance of early intervention as preventative of later development of disturbance - the first in relation to a young vulnerable looked after child, the second in relation to establishing a more secure and loving attachment between a mother and her baby. The need for ante-, peri- and post-natal paediatric services to be fully integrated with other interventions was also emphasised, given the possibility that the premature birth of the baby in the second case study might have affected the problems described.

The Role of the School in Preventing Mental Health Problems and Promoting Well-being. What does the evidence say 'works'?

Katherine Weare

Katherine Weare, Emeritus Professor of Education at Southampton University and Visiting Professor at Exeter, began by explaining that although the need to deal with children's mental health problems is a common challenge for schools, there is confusion because each agency tends to use its own language. The list of terms is extensive and includes: resilience, grit, character, mood, virtue, well-being, mental health, emotional intelligence, social and emotion learning etc. Each agency also tends to have its own focus and the division of responsibility and structure of services often reflects false dichotomies, such as between cognitive and non-cognitive psychological processes. No single term is ever going

to be appropriate but although this is confusing, it does not matter because it is principles that matter and there is usually more consensus about them.

'What works' discussions are informed these days by a plethora of validated interventions, including SEAL (social and emotional aspects of learning) developed by Katherine and widely implemented in the UK. This, along with others, such as TaMHS (targeted mental health in schools), has created an auspicious base for introducing evidence-based practice. But one lesson that has been learned is that while the fundamental concepts, such as mindfulness, are clear, they need to be well taught and the provision of good quality services is not just a question of money.

In the last week, the National Children's Bureau has published Katherine's report *What Works in Promoting Social and Emotional Well-being and Responding to Mental Health Problems in Schools? Advice for Schools and Framework Document*. This demonstrates the best ways of promoting the well-being of pupils and achieving a balance between general and targeted provision. To establish this, she scrutinised more than 50 reviews of high quality studies, in the sense that they were based on robust samples and control groups, and assessed numerous evaluations of individual projects. She also considered evidence emerging from associated disciplines such as neuroscience. Particularly helpful to this exercise was the work of CASEL (collaborative for academic, social and emotional learning) in the US which compares the outcomes for children attending schools with different approaches to well-being and confirms that what schools do actually makes a difference.

The conclusion from this exercise was that well implemented programmes delivered in schools and elsewhere can have an impact on children's well-being and ameliorate the difficulties associated with such things as depression, emotional regulation and underachievement. But they have to be well implemented and complemented by aspects such as modelling by staff and other pupils. In addition, it is essential to abolish false dichotomies. Well-being is often contrasted with academic attainment, as if one weakens the other, but this is misleading because both go together with success in one area improving outcomes in the other.

Perhaps the most important message is the obvious benefit of developing a 'whole school' approach underpinned by joined-up thinking. The NCB report highlights the features that promote this, such as leadership, listening to pupils' views and establishing links with CAMHS. It suggests ways of overcoming compartmentalised thinking and the defensive protection of budgets. But again, while a 'wider the better' perspective is to be welcomed, it has to be well organised and implemented, a problem that confounded the SEAL and the Every Child Matters projects.

The features of effective schools

So what are the important features of successful schools? The overall principles and values that inform the ethos of the school are obviously important but these

need to be translated into a clearly designed system that is embodied into every aspect of school life in an intelligent way. Hence, they have to be manifest in organisational aspects, such as valuing pupils' views, seeing parents as partners, involving all school staff and not just teachers, the provision of counselling services and good collaboration with the local CAMHS.

But one difficulty is achieving the right balance between universal and targeted services. We can't have one without the other but how can universal interventions be delivered without creating stigma? Again, the problem is partly structural as it is exacerbated by adopting too rigid a division between options. Rather than an 'either/or' approach, the need is for a system of graduated support operating in a context where the ethos is auspicious for promoting children's well-being.

The evidence also shows that it is important to start providing help early in the child's life, to keep it going and ensure it is consistent.

Then there are benefits from raising awareness of mental health problems – among children and staff – but to do this without frightening people. This does not mean that teachers need to be therapists but that they should be helped to recognise the signs of problems, understand their nature and know what to do about them, and to feel supported in this. The aim is to try and go beyond descriptions and seek answer to the 'why' questions. Older people also have to keep up to date with the modern communication methods used by young people as these are becoming increasingly important influence on children's well-being.

Finally, we have to get staff to stand up to the stigma associated with mental health as this is often a source of bullying and to remember that these issues also affect them.

In conclusion, the messages for service directors and staff are to: focus on strengths, encourage positive emotions, address risks and build resilience, acknowledge that factors outside the school, such as poverty and family tensions, that can affect children, listen to the young people, help staff feel that pressures emanating from outside are not being imposed on them, allow expressions of negative emotions, develop a programme of professional development for staff and ensure they have a satisfying work-life balance. In terms of specific skills, the school should develop an ethos that is considerate to others, provides core instruction on social and emotional issues and integrates this into the wider curriculum, involves families and keeps things simple but well taught.

Using large-scale population data on children's well-being to develop services in local communities

Tim Hobbs and Daniel Ellis

In the final session, Tim Hobbs and Daniel Ellis from the Dartington Social Research Unit discussed their study in Scotland in which all children aged 9-15 in three local authorities completed a well-being questionnaire and a

representative sample of parents was interviewed. The results were linked to information on children's use of specialist services provided by local agencies - by which is meant services in addition to those available to all children like education, libraries and health care. It forms part of two wider research initiatives *Evidence2Success* and *Improving Children's outcomes*, details of which can be found on the Unit's website www.dartington.org.uk.

The aim is to improve outcomes for children at a population level by collecting background information on children's needs and using this to improve services. One example would be reassessing the balance between prevention, early intervention and treatment. This exercise requires careful governance as it has to have the support of all executives, service directors, community leaders and politicians as well local parents and children and every school in the area. The aim is to institute an ethos of a structured process supporting joint accountability between public systems and communities for outcomes and expenditure.

Once sufficient cross-agency consensus has been achieved, patterns of local spending on children's services are charted. In total, this tends to range from £4-6,000 per child, mostly on education and with very little on mental health. In the next stage, 2% of this money is identified as available to fund investments in prevention, early intervention and evidence-based or science-informed approaches to improve services. The data on all children in the area are then scrutinised to see what areas might be amenable to change and likely to improve children's well-being. In this process, the 'what works' literature is reviewed to inform the decisions. The changes are then introduced and monitored over a five or ten year period.

An example was given using data collected in three local authorities in Scotland. Every child (22,400) aged 9-16, completed a well-being questionnaire and a threshold was applied to the answers to select those who displayed a need in five or more areas of their lives. Just under a quarter (23%) of the children met this criterion. The parallel audit of service use showed that 12% of all 22,400 children were receiving some kind of specialist service. Of this 12%, only 26% (i.e. 3.12% of all children) of them fell into the high need group. This means that on average, 86% ($19.88 \div 23$) of all those with high need were not receiving a specialist service. Similarly, 74% of the 12% ($8.88 \div 12$) who did get a specialised service did not fall into the high need group. This limited overlap indicates not only a lot of unmet need but also the fact that some children are receiving services unnecessarily.

The method of analysing and presenting the results was then described. The needs revealed in the questionnaires are measured at a population level and the impact of influential factors, as identified from the research literature, assessed. These data are then incorporated into a visual model whereby everyone in the local authority can access the results, compare the prevalence of factors in their area with an average across the authorities then click onto each outcome to see the further details and associated risk factors. This provides essential information on the extent of the problems and the factors in the community

associated with them, so facilitating discussions about ways of improving children's well-being. An important spin-off from the exercise is that there are benefits at the local level, for example each school gets a profile of the needs of its pupils which shows how this compares with the results for the whole local authority.

Summary points

The chair of CSP, James Wetz, then summarised some of the key issues raised in the seminar.

These included:

The scale, gravity and complexity of the problem

The depth of unmet need and the pain associated with it

The quality of the resources needed to address the needs of the children

The realisation that there is no quick fix

The need for all agencies to be involved, not just the NHS

The persistence of problems despite the abundance of goodwill.

The availability of a methodology to create robust evidence on needs

The availability of evidence-based guidance for managers and practitioners