



5-10 years

Missed opportunities: children and young people's mental health

During middle childhood, children's developing mental health continues to be sensitive to family environmental risk and protective factors; however, during this period most children in this age group also experience daily exposure to a new and highly significant environment – school. Early educational environments have the potential to provide new nourishing and potentially protective experiences promoting a child's mental health; but they can also expose children to new risks as they venture independently into new social settings. Schools, and the tasks they require of children, can also be the context within which children's mental health or neurodevelopmental difficulties first begin to surface or become entrenched. For children who come from less than optimum home backgrounds and neighbourhoods, school environments can redress risk factors providing a turning point and compensatory protective factors (Gross, 2008).

Broadly speaking, children's mental health appears to deteriorate over time and as they accumulate risks.

An analysis of longitudinal data collected on children in English primary schools pointed to a degree of unpredictability and fluctuation in levels of wellbeing experienced by children during these school years. Although most children experienced improvements in wellbeing between the ages of eight and ten, 2% of children had persistent poor wellbeing during this entire time frame. Furthermore, another 6% of children also suffered deterioration in wellbeing from previously average or higher levels (Gutman & Feinstein, 2008). Gutman and Feinstein's (2008) research noted general continuity between patterns of risk and protective factors and risky behaviours at age eight compared with age ten. For example:

- Eight year olds who talked to their teacher, liked school and expressed satisfaction with their friends were more likely to be happy with all these aspects of their school lives at age ten.
- Children who were bullied at age eight were also more likely to be bullied at age ten.

- Children with behavioural problems at age eight were more likely to persist with these patterns at age ten, talked less to their teachers, liked school less, and were less satisfied with their friendships (Gutman & Feinstein, 2008).

For a minority of children, negative experiences and behaviours appeared not only to continue but also multiplied during these years leading to cascading risks and cementing negative experiences and trajectories (Posner, *et al.*, 2000; Gutman & Feinstein, 2008).

Prevalence of mental health difficulties

Overall, around 8% of children will have a diagnosable mental health problem during middle childhood. At this stage in life, boys are more likely than girls to have a diagnosable mental health difficulty. The last national survey (2005) indicated that:

- The most common diagnosable mental health difficulty (affecting around one in 20 or 5% of children in this age group) is conduct disorder – or severe and persistent behavioural problems.
- Just over 2% of 5-10 year olds had a diagnosable anxiety-related or depressive illness (with the majority presenting with anxiety-related conditions).
- Just over 2% (again mostly boys) presented with diagnosable hyperkinetic conditions – difficulties which significantly impair attention and hyperactivity.
- Just under 2% presented with other diagnosable difficulties such as autistic spectrum conditions (1%), tic conditions (0.1%), eating disorders (0.3%) and mutism (0.1%).
- Based on parental report self-harming has historically been rare at this age (estimated to affect around 2% of children in 2004, although reliable data for this age group are lacking and there has been growing anecdotal concern about self-harming starting earlier with children being influenced by friends and siblings).

(Green, *et al.*, 2005).

Broadly speaking, girls were marginally more likely to present with emotional problems (including generalised anxiety, post-traumatic stress syndrome and separation anxiety) than boys. On the other hand boys were twice as likely to present with severe behavioural problems, nearly seven times as likely to present with hyperactivity and attention-related problems and 19 times as likely to have autistic spectrum conditions (Green, *et al.*, 2005).

Conduct disorder is the most common mental health problem affecting children in this age group. The school environment can often be the first place that such difficulties gain wider attention having previously been contained within the family unit. There is robust evidence that difficulties reaching diagnosable levels before the age of secondary school significantly undermine children's life chances across a range of domains (Fergusson, *et al.*, 2005). These children also have a higher risk of suffering from almost all adult mental illnesses (Kim-Cohen, *et al.*, 2003; Rutter, *et al.*, 2006). Half of these children will continue to face elevated risk of multiple poor outcomes without effective early intervention (Centre for Mental Health, 2012).

A recent study noted a significant overlap between children excluded from school and those with symptoms of conduct disorder (Cole, 2015). However, the health dimensions of their behaviour can often be overlooked or inconsistently considered with proven responses used patchily to de-escalate risk (Khan, 2014; Cole, 2015). Primary school exclusions present a particularly important opportunity to use evidence based approaches to improve children's outcomes. Over the last year we note slightly higher numbers of permanent primary school exclusions (albeit that this group will be a small sample) mainly due to aggression directed at teachers or other children (Department for Education, 2015). This trend requires ongoing monitoring as it may reflect reduced resources or tolerance in schools for supporting and managing children with conduct problems, or on the other hand, reduced access to effective interventions such as NICE-recommended early parenting programmes.

Figure 1: Poorer life chances for children with conduct disorder

NEGATIVE OUTCOMES

2 x MORE LIKELY TO LEAVE SCHOOL WITH NO QUALIFICATIONS



6 x MORE LIKELY TO DIE BEFORE AGE 30



3 x MORE LIKELY TO BECOME A TEENAGE PARENT



8 x MORE LIKELY TO BE ON THE CHILD PROTECTION REGISTER



4 x MORE LIKELY TO BE DEPENDENT ON DRUGS



20 x MORE LIKELY TO END UP IN PRISON



Parsonage *et al.*, (2014)

Between a quarter and a third of children with a diagnosable mental health condition had more than one diagnosable mental illness. In the case of conduct disorders, over half in this age group had more than one diagnosis.

Children's mental health and wellbeing falls across a spectrum. We know a lot about the impact that conduct disorder at this young age has on children's lives and adult life chances (Centre for Mental Health, 2009) but there is less clarity on patterns of persistence with diagnosable emotional conditions. There has also been far less research on the outcomes faced by those with difficulties falling just below clinical cut-off points who may nevertheless face considerable and ongoing challenges in their lives.

Trends over time

There has been a mixed picture emerging on the state of children's mental health during middle childhood with no clear evidence of any strong trend.

Comparison of previous national surveys and birth cohort studies generally suggest deterioration in children's mental health between the late 1970s and the millennium. Thereafter, at least for children in middle childhood, mental health appeared to plateau or possibly even improve. For this age group, this trend has been consistent regardless of gender and applies particularly to behavioural conditions but also in some cases to emotional problems (Green, *et al.*, 2005; Maughan, *et al.*, 2008; Bor, *et al.*, 2014; Sellers, *et al.*, 2015; Morrison Gutman, *et al.*, 2015).

Sellers (2015) compared prevalence rates of seven year olds in a number of past and current surveys and longitudinal studies.

Analyses focused on children living in England, Scotland and Wales and compared parent- and teacher-completed Strengths and Difficulties Questionnaires – a tool considered to provide a reliable proxy for identifying children within clinical ranges (Goodman, *et al.*, 2000). Despite concerns and anecdotal fears of mounting distress and increased demand for services (Sourander, *et al.*, 2008), Sellers did not find increases over time in the prevalence of mental health diagnoses in the 2008 cohort. In fact findings pointed to overall improvements in child mental health over a ten year period for almost every diagnosable condition. Reductions in symptoms were present for boys and girls, although the scale of improvement for seven year old boys was greater than for girls. A more recent study, focusing on the same cohort at the age of 11 years again revealed no overall increase in the prevalence of diagnosable conditions as they moved towards early adolescence (Morrison Gutman, *et al.*, 2015).

Sellers (2015) speculated that these possible decreases in the prevalence of primary school children's mental health problems may be due to:

- Overall reductions in absolute family poverty and income inequality since it peaked during the late 1990s;
- Increased early intervention (e.g. understanding of perinatal issues and increased investment in early years and evidence based parenting programmes during the mid-2000s).

These observed improvements should of course be considered with caution. More good quality investigation is needed to conclude on these trends. Furthermore, improvements may not persist into adolescence and a small number of studies suggest deteriorations in mental health as children approach middle adolescence – particularly in relation to emotional problems and among girls (Collishaw, *et al.*, 2010; Sweeting, *et al.*, 2010). There is also now some indication that child poverty and income inequality may be worsening in Britain in recent years with particular impact noted on children and young people (Joseph Rowntree Foundation, 2015). The planned 2016/17

child and adolescent mental health survey will provide a more reliable and up to date analysis across time from which we will be able to draw conclusions.

Major risk factors

Risk and protective factors (both temperament-based and environmental) continue to interact during primary school years, building on children's early experiences and influencing their wellbeing. Over time, wellbeing can be shaped by carer, family structure, teachers, school context, peer groups and neighbourhood level factors in both positive and negative ways. There is a wealth of high quality evidence which suggests that if risk factors accumulate and persist over time, this can be highly detrimental to a child's mental health and wellbeing (Aguilar, *et al.*, 2000; Appleyard, *et al.*, 2005).

Children with warm and supportive relationships with parents/carers have better socio-emotional adjustment including lower levels of behavioural problems (Bronstein, *et al.*, 1996). Indeed, the quality of parenting (particularly harsh parenting and lack of supervision) accounts for 30-40% of severe and persistent poor behaviour in children (Patterson, *et al.*, 1989).

As with early childhood, studies show that some parental characteristics and circumstances have greater likelihood of compromising children's mental health than others.

Parental mental ill health

In 2008, roughly two million children in the UK were estimated to live in households where at least one parent had a mental illness (Parrott, *et al.*, 2008). Most parents with mental illness are responsive and sensitive parents and children will be unaffected by parental mental illness (SCIE, 2011). However, poor parental mental health is one of the most consistent and potent risk factors for the development and persistence of diagnosable mental health problems in children (Leinonen, *et al.*, 2003; Hosman, *et al.*, 2009). Studies suggest, for example, that between a third and two thirds of children whose parents have mental health problems

will experience emotional and behavioural difficulties themselves (Social Exclusion Unit, 2004). Mothers are generally more likely to be diagnosed with poor mental health than fathers (SCIE, 2011).

The association between parental and child mental health is complex. Influences are likely to be bi-directional (e.g. parents' poor mental health affects children's mental health, but also a child's poor mental health affects a parent's mental health).

The relationship between parent and child mental health is also likely to be linked to a range of interacting biological, social and environmental factors including:

- The child's temperament;
- The impact of parental illness on family resources and stability (particularly employment or increasing exposure to poverty);
- The impact of mental illness on the quality of parental relationships;
- The extent to which parental mental illness affects their sensitivity and responsiveness, child attachment, parent-child interaction and parents' ability to buffer children from cumulative stress and adversity;
- The consistency of positive parenting.

This does not mean that those with poor mental health are poorer parents (Hosman, *et al.*, 2009). But poor parental mental health may intermittently undermine critical carer sensitivity and energy to adopt authoritative/positive parenting, with affected parents cycling between states of wellness and poor mental health (Hosman, *et al.*, 2009). Families with parents affected by mental illness are also more likely to experience poverty, unemployment and associated survival and financial stresses which we know also impact on family cohesion and child mental health (Zeanah, 2012). Poorer child outcomes may equally be linked to the cumulative impact of all of these events (Donga, *et al.*, 2004; Hillis, *et al.*, 2001) as well as straitened financial circumstances more commonly affecting those living with diagnosable conditions.

Parents reliant on drugs and alcohol

There is generally poor knowledge on the number of children living with a parent who misuses substances (Ofsted, 2013). In 2002, roughly a million children were estimated to be living in a family with a problem drinker parent (Tunnard, 2002). Estimates also suggested that around 200,000 adults were receiving treatment for substance misuse problems, of whom one third were parents and had children living with them (Ofsted, 2013).

Studies indicate that children of parents who misuse substances are more likely to experience poorer emotional, psychiatric and behavioural outcomes (Hogan, 2003), to have a higher likelihood of reliance on substances themselves (Christensen & Bilenberg, 2000) and to face a range of other physical and educational problems (Conners, *et al.*, 2001). As with poor parental mental health, it is as yet unclear whether poorer child mental health outcomes can be isolated and attributed directly to parental substance misuse itself or are linked to other aspects of disadvantage (Fals-Stewart, *et al.*, 2004; SCIE, 2004). This requires more investigation. Research also shows, as with mental illness, that the impact of substance misuse can be mitigated by a second parent, or care by extended family involvement and early community support (Sawyer & Burton, 2012).

Maltreatment, abuse and neglect

Definitions of maltreatment generally include:

- Physical abuse;
- Sexual abuse;
- Psychological or emotional abuse;
- Neglect.

Increasingly, both witnessing and experiencing intimate-partner violence is being regarded as a form of child maltreatment.

Securing accurate data on the number of children affected by child maltreatment is challenging with most official information significantly under-recording prevalence (MacMillan, *et al.*, 2003). For example, there is generally a tenfold discrepancy between

the number of children officially recorded as maltreated by child protection agencies and rates reported by victims or children (Gilbert, *et al.*, 2009). Indeed, one international study identified that only 5% of children who were physically abused and 8% of those who were sexually abused had reported contact with child protection services (MacMillan, *et al.*, 2003). Recent analysis of data collected through the Children's Commissioner estimated that only one in eight children who had been sexually abused came to the attention of statutory agencies (Children's Commissioner, 2015). Another study indicated that even children who were in contact with child protection services reported six times more abusive experiences compared with official records (Everson, *et al.*, 2008). Most children don't disclose sexual abuse until after the age of 18, yet most children reported initiation of abuse at around the age of nine (Children's Commissioner, 2015).

Lack of accurate data on experiences makes it particularly difficult to track trends over time. Despite these challenges, there is some indication that overall maltreatment may be slightly decreasing over time although reporting rates for some forms of abuse are rising (NSPCC, 2011). Figure 2 sets out the estimated levels of different types of abuse.

Many children will experience more than one type of abuse. Overall, girls are marginally more likely to experience overall maltreatment during childhood and they are significantly more likely to experience sexual abuse (Gilbert, *et al.*,

2009) although during early years and primary school years the number of male and female victims of abuse remain relatively equal (Children's Commissioner, 2015). Disabled children were also noted to have a significantly elevated risk of experiencing maltreatment compared with non-disabled children (31% versus 9% in one study) (Gilbert, *et al.*, 2009).

Mixed heritage children were at higher risk of experiencing maltreatment even after controlling for other risk factors for abuse and neglect, such as socio-economic deprivation (Gilbert, *et al.*, 2009).

80% or more of maltreatment is perpetrated by parents or parental guardians. In the case of sexual abuse, there is mixed evidence on the most likely perpetrators. The NSPCC found that known adults (including parents, guardians and non-resident adults such as neighbours or family friends) were the most frequently reported perpetrators of adult perpetrated contact sexual abuse (NSPCC, 2011). Gilbert *et al* (2009) found that sexual abuse was more likely to be perpetrated by acquaintances or other relatives (Gilbert, *et al.*, 2009). Men have been noted as much more likely than women to perpetrate sexual abuse whilst women were more likely to be responsible for neglect (Sedlak, *et al.*, 2010). Parental risk factors for maltreatment have been identified as poverty, parental mental health problems, low educational achievement, parental alcohol and drug misuse and parental exposure to maltreatment as a child. Community environment has also been associated with poorer outcomes resulting from maltreatment

Figure 2: summary of prevalence rates for child maltreatment (adapted from Gilbert *et al.*, 2009)

Type of abuse (self-report)	Ranges identified (%)	Girls	Boys
Physical abuse	5-35	Not available	Not available
Any sexual abuse	15-30	15-30	5-15
Childhood sexual abuse (penetrative)	Not available	5-10	1-5
Non-contact sexual abuse	Not available	15-30	5-15
Neglect	6-12	Not available	Not available
Severe neglect	1-10	Not available	Not available
Psychological abuse	4-9	8-9	4
Exposure to Intimate Partner Violence	8-25	Not available	Not available

(amplifying family and individual risk factors). Adverse features of community environment affecting children's outcomes included high crime, low social cohesion and informal mechanisms of social control (Jaffee, *et al.*, 2007).

Child maltreatment has lifelong consequences for children. Studies reveal strong associations between all experiences of maltreatment in childhood and poorer emotional and behavioural health including anxiety, depression, post-traumatic stress, suicide, self-injury, dissociation and severe and persistent behavioural problems (Lanktree, *et al.*, 2008). Maltreatment is also linked to increased explosive anger and aggression and risk taking (use of drugs and alcohol, age inappropriate sexual behaviour and crime) (Lanktree, *et al.*, 2008; Gilbert, *et al.*, 2009; NSPCC, 2011). In 2006, the World Health Organisation (WHO) called for greater public health prominence to be given to this important risk factor affecting children's outcomes (Gilbert, *et al.*, 2009).

Longitudinal studies tell us that child maltreatment can have a very long-lasting impact on children's ability to regulate their emotions and behaviour with effects persisting into adult years. Such experiences also increase the chances of school failure, risky substance misuse and sexual behaviour, employment difficulties, lower income, obesity and criminal behaviour (Gilbert, *et al.*, 2009).

More work is needed to understand whether exposure at any one particular time in childhood is more damaging than at any other (for example, to what extent infant neurodevelopment is affected by early maltreatment and to what extent infants can recover). There is some evidence that the earlier risk is escaped, the more children benefit across a range of developmental domains (Kumsta, *et al.*, 2015). There is also evidence that exposure to ongoing, severe and cumulative maltreatment is highly detrimental to children's mental health and wellbeing with effects not only in middle childhood and adolescence (e.g. exacerbating behavioural and emotional regulation) but also linking to young adult suicide risk and adult depression (Gilbert, *et al.*, 2009).

Children experiencing prolonged and multiple abuse had higher risk of subsequent victimisation. Findings suggest that risks of victimisation ripple out and multiply during a child's life course - moving from victimisation by parents/care-givers to include abuse by perpetrators outside the home and in non-familial relationships (e.g. victimisation by bullies, sexual exploitation, intimate partner violence) (Finkelhor, 2008; Finkelhor, *et al.*, 2009). In this respect, research highlights the need to intervene early before early child mental health difficulties embed and cascade into other spheres of their life (Gilbert, *et al.*, 2009).

Domestic violence

12% of under eleven year olds have reported exposure to domestic violence or intimate partner violence (NSPCC, 2013). In reviews of research studies, partner violence was associated with child trauma, high levels of family stress and higher likelihood of children experiencing severe behavioural problems and anxiety. They were also at elevated risk of depression and alcohol use in adult years (Gilbert, *et al.*, 2009). There is some debate (and a need for further investigation) as to whether intimate partner violence on its own is responsible for poor mental health outcomes or whether effects are reliant on and amplified by exposure to other forms of maltreatment and risk factors (Gilbert, *et al.*, 2009). For example, around a third of children affected by domestic violence were also the direct victims of child physical abuse (Hamby, *et al.*, 2010).

Exposure to family breakdown, conflict and bereavement

There is also some evidence that children who have experienced family breakdown, conflict or bereavement have poorer mental health than those not exposed to these experiences (Green, 2005). For example, children living with a lone parent who had been widowed, divorced or separated had almost a twofold higher risk of experiencing diagnosable emotional difficulties; bereaved children were approximately one and a half times as likely to be diagnosed with 'any disorder' (Fauth, *et al.*, 2009).

Bullying

Exposure to bullying in school is a major risk affecting children's mental health and wellbeing. Studies show that children who have been bullied have higher prevalence of poor mental health and also face a range of other persistent adverse outcomes across their life course.

Bullying often begins as children enter school and forge broader social relationships during infant and primary school years. Prevalence rates for bullying vary considerably depending on definitions used and how questions about frequency of experiences are framed. One in three children say they have been bullied at some point in their lives and around 10-14% report longer term bullying of more than six months' duration (World Health Organization, 2012). Between 2% and 5% of children are bullies and a similar number are both bullies and victims in childhood and adolescence (Wolke & Lereya, 2015). Current evidence suggests that rates of cyberbullying are not higher than rates of traditional bullying but this requires ongoing investigation; reports also suggest significant overlaps between the two forms of bullying (Wolke & Lereya, 2015).

Being bullied by other children is the most frequent form of abuse experienced by children – much higher than abuse by parents or other adults (Radford, *et al.*, 2013).

Studies indicate that victims of peer aggression have:

- Generally lower self-esteem than non-victims;
- Higher levels of social isolation;
- Greater risk of health problems (particularly young female victims);
- Higher rates of mental health problems.

(Kumpulainen, *et al.*, 1998; Hawker & Boulton, 2000; Wolke, *et al.*, 2001)

Children and young people also describe experiences of bullying affecting their sleep and undermining concentration, academic performance and family and social relationships. Some of those who had

been cyberbullied reported higher levels of aggression and behavioural problems at school including lower attainment, reduced attendance and getting into trouble (Hamm, *et al.*, 2015).

Among girls aged 7-12, one in four in a recent survey said they had been bullied because of their appearance (25%) (Girls' Attitudes Survey, 2014).

Evidence increasingly confirms that being a target of bullying in childhood, and particularly frequent bullying, has pervasive negative effects on children's mental and physical health, and social, educational and economic development which seem to persist for at least four decades (Takizawa *et al.*, 2014). In the US, based on these findings, calculations suggest that prevention of bullying could result in lifetime savings of over 1.4 million dollars per person (Masiello, *et al.*, 2012; Wolke & Lereya, 2015).

Children do not all fit into polarised categories of being either bullies or victims; some are both victims and perpetrators simultaneously (Wolke & Lereya, 2015). Indeed, many studies found that experiences of bullying and victimisation increased the probability of engagement in later bullying (Barker, *et al.*, 2008).

Children and youths who were both victims and perpetrators were noted to be much more common at primary school stage and to have far poorer life chances (Haynie, *et al.*, 2001). Bully-victims felt less safe at school, felt uncared for by teachers, had lower self-esteem, had more suicidal thoughts and later on in life had greater risk of attempting suicide (Patchin & Hinduja, 2010; Patchin & Hinduja, 2011; Patchin & Hinduja, 2012).

Although not all children who bully go on to offend, bullying during middle childhood has been noted to increase the chance of later criminal activity particularly self-reported violent offending, weapon carrying and arrests (Hinduja & Patchin, 2010; Ybarra & Mitchell, 2004). Bully perpetrators also have the highest risk of suicide during young adult and adult years (Klomek, *et al.*, 2010). These risks were quite independent of the risk that any child with early starting behavioural difficulties might

have of increased offending (Fergusson, *et al.*, 2014).

Gutman and Feinstein's study (2008) tracked an incremental two-year deterioration during primary school years in the frequency with which bullies talked to their teachers, liked school and were satisfied with friendships – findings which supported the likelihood of poor behaviour worsening over time due to escalating negative experiences (Posner, *et al.*, 2000). Other studies have also pointed to bullies having low school bonding and academic competence (Haynie, *et al.*, 2001).

There is mixed evidence on the gender split of bullying and peer victimisation. Boys are noted as more likely to be bully/victims than girls (Pellegrini & Long, 2002) and also to be involved in more face to face and direct bullying (Bongers, *et al.*, 2004; Wolke, *et al.*, 2001). Some studies indicate girls favour more indirect and psychological aggression (Salmivalli, *et al.*, 2005).

The evidence on likelihood of victimisation by gender presents a less clear picture. Boys tend to score generally higher on victimisation scales but some studies indicate no gender differences (Rose & Rudolph, 2006) and still others show the reverse is true (Veenstra, *et al.*, 2005).

Bullying historically has been noted to decrease with age (Smith, *et al.*, 2001); but findings may pre-date increased opportunities emerging through digital culture. The frequently repeated General Health Questionnaire in Schools, however, which should by now be capturing some impact of cyberbullying, does not indicate overall increases in bullying in the UK. Indeed, there is evidence that bullying (reports of ever being bullied and experiences of regular bullying) in England and Wales decreased between 2001 and 2010. In Wales experiences of regular bullying increased by 15% between 2001 and 2006 but then subsequently decreased by around 15% between 2006 and 2009/10. However, for boys in Scotland, there has been a 5% increase in bullying since 2006.

Children with disabilities or long term physical health conditions

Children with learning disabilities have been noted to face or be living with higher levels of mental health difficulties compared with those without such disabilities. They are:

- 33 times more likely to have an autistic spectrum condition;
- Eight times more likely to have attention deficit and hyperactivity condition;
- Six times more likely to have a conduct disorder;
- Four times more likely to have a diagnosable emotional mental health problem;
- Three times more likely to have psychosis as they move into adolescence/early adult years;
- Nearly two times more likely to have a depressive disorder.

(Emerson & Hatton, 2007)

Children with physical disabilities also appear more likely to experience victimisation (GirlGuiding, 2014).

Children with chronic physical health problems and disabilities are also noted to be twice as likely to have diagnosable mental health difficulties as other children (Hysing, *et al.*, 2007).

What works?

Universal programmes in schools to prevent poor child mental health

Ordinarily, programmes targeted at all children are overall less effective and cost effective than those targeted at children in higher risk groups or presenting with early symptoms. However, schools provide a rare context within which universal programmes have been noted to result in moderately sized improvements to whole child population mental health, but with particularly notable gains for higher risk children (Weare & Nind, 2011).

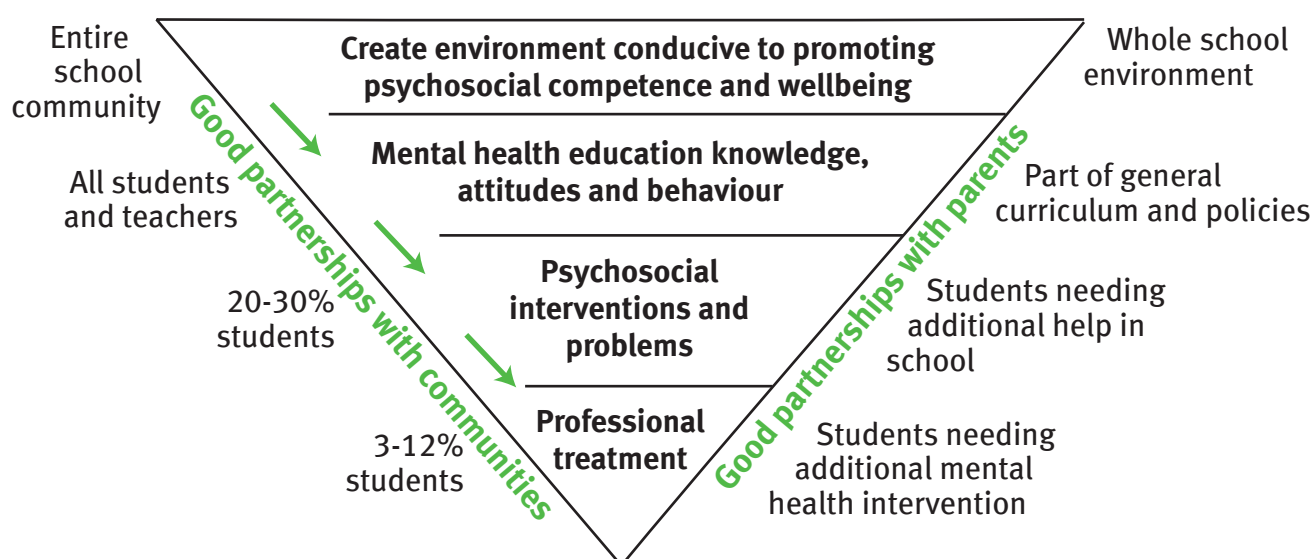
Many evidence based social and emotional learning programmes focus on improving social, emotional and academic competencies (see Figure 3), helping young people to regulate behaviour and emotions when faced with worries, frustration and setbacks. Programmes such as PATHS and the Good Behaviour Game (described opposite) appear so far to have greater proven effectiveness during primary school years (Washington State Institute for Public Policy, 2015). Proven programmes must form part of a Whole School Approach to promoting mental health and wellbeing and should be reproduced faithfully (not adapted or

dipped into). Programmes should be delivered by well trained and supervised staff (Durlak & DuPre, 2008); they often fail because of poor quality implementation or ineffective delivery. These universal programmes also work best when complemented by access to targeted programmes for those with higher needs (see Figure 3).

The World Health Organisation's Whole School Approach (see Figure 3) sets out a framework for whole school cultural change and intervention promoting children's mental health.

To be successful, mental health promoting and anti-bullying approaches need to be owned by all school staff, threaded throughout the curriculum and embedded in school culture. They should be backed up by policies, good links with parents and outside agencies, swift action to support wellbeing and whole school staff training and commitment to promoting children's mental health and wellbeing (Weare & Nind, 2011). Faithful delivery of school-based programmes can be challenging for schools preoccupied with prioritising national curriculum targets, even if in the longer term they promote educational attainment (Durlak & DuPre, 2008).

Figure 3: Whole School Approach to mental health (adapted from Wyn *et al.*, 2000)



Examples of effective universal programmes supporting healthy emotional, behavioural and social wellbeing

Classroom based **Social and Emotional Learning (SEL)** programmes are noted to be effective in promoting better mental health in children and better educational outcomes, and to be cost effective (Durlak & DuPre, 2008; Knapp, *et al.*, 2011; Washington State Institute for Public Policy, 2015). To be effective they must form part of a broader Whole School commitment to promoting mental health and emotional wellbeing (Durlak & DuPre, 2008). It also takes time for the impact of such programmes to pay dividends, often with secondary schools benefitting from primary school intervention (Durlak & DuPre, 2008).

SEL programmes are designed to promote the development and application to learning of social and emotional skills that have been classified under the five domains of Goleman's (1995) model of emotional intelligence. These domains include self-awareness, self-regulation (managing feelings), motivation, empathy, and social skills. At the school level, SEL is characterised by the following principles:

- Being underpinned by clear planning focused on improving standards, behaviour and attendance;
- Building a school ethos that provides conditions to promote social and emotional skills;
- All children are provided with planned opportunities to develop social and emotional skills;
- Adults are given opportunities to enhance their own social and emotional skills;
- Staff recognise the significance of social and emotional skills to effective learning;
- Pupils who would benefit from additional support have access to small group work;
- There is a strong commitment to involving pupils in all aspects of school life;
- There is a strong commitment to working positively with parents and carers;
- The school engages well with other schools, the local community and wider services.

The **Good Behaviour Game (GBG)** is a two-year classroom management strategy targeted at 6-8 year olds and designed to improve aggressive/disruptive classroom behaviour and prevent later conduct problems/antisocial behaviour. The programme, delivered to all children in this age band, costs around £100 to deliver per child but with savings now noted over time of more £50 for each pound invested in the programme. Across a whole school population, benefits and savings could be substantial (Washington State Institute for Public Policy, 2015). Two trials of this programme are currently under way – one in England and another in the Republic of Ireland.

The **Promoting Alternative Thinking Strategies (PATHs)** curriculum is one example of an effective classroom social and emotional learning (SEL) programme. It is adapted for different age groups and can be initiated from preschool years and continues through to the age of 13. The primary school version aims to create an environment that helps young children from three to six years develop better self-control, self-esteem, emotional awareness, basic problem-solving skills, social skills, and friendships. The curriculum provides teachers with systematic, developmentally-based lessons, materials, and instructions for teaching their students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. SEL skills have been shown to improve school attainment and prevent and reduce the development of emotional and behavioural problems (Durlak & DuPre, 2008; Washington State Institute for Public Policy, 2015).

Although there is good evidence internationally about the effectiveness of these programmes in supporting improved emotional and social skills, successful results have not consistently been replicated in the UK. An attempt at national rollout and implementation in late 2000 produced very mixed results and overall had a negligible impact in terms of improving children's mental health and wellbeing. It was speculated that this lack of success in the UK was linked to excessively speedy rollout on a large scale, inconsistency and lack of quality control in the way they were implemented, lack of time to generate the required whole school culture and restricted time and resources, all of which international research has noted affect successful reproduction (Humphrey *et al.*, 2010).

A more recent evaluation by the University of Manchester also concluded that PATHS had not resulted in any immediate gains specifically in terms of educational attainment (Humphrey *et al.*, 2015). However, a report investigating broader health and wellbeing benefits from the trial is due imminently. It should also be noted that many of the benefits from these programmes do not tend to surface until later in a child's school career (Durlak & DuPre, 2008) requiring longer term follow-up which has not been planned as part of this recent PATHS trial. When implemented well, systematic evidence reviews suggest that for every pound invested, savings can be expected of around £5 (Washington State Institute for Public Policy, 2015).

Bullying interventions in schools

Overall, bullying interventions produce inconsistent results. Some anti-bullying interventions have been noted to result in at least a 30% reduction in bullying in schools (Olweus, 1994), while others have no effect or even seem to increase the amount of bullying (Farrington & Ttofi, 2009). Many school based bullying programmes have struggled consistently to produce or replicate positive results. For example, in one review of the evidence only 4 out of 10 programmes evaluated reduced bullying. Furthermore, even the most successful programme to date, the

Olweus Programme developed in Norway, has been unable to consistently replicate initial positive results (Vreeman & Carroll, 2007; Roland, 1993).

Key features increasing the likelihood of reductions in bullying include:

- That programmes should include clear and explicit guidance on how to implement and reproduce them successfully;
- That programmes should not just be stand-alone classroom level activities; rather, they should address the systemic and environmental risks related to bullying - anchored in a whole school cultural commitment (including teachers, students, support staff and parents) to developing and publicising policies, monitoring playground interactions, and addressing and reducing bullying.

(Vreeman & Carroll, 2007; Farrington & Ttofi, 2009).

More research is currently required into understanding:

- Differences and overlaps between cyberbullying and traditional bullying;
- Effective anti-bullying approaches and programmes (particularly those targeted at cyberbullying);
- Critical variations in implementation affecting programmes previously demonstrating promise.

Since bullying can often form part of a larger spectrum of conduct problems, evidence based parenting programmes may also be effective as a first port of call supporting parents of children who bully during primary school years (National Institute for Health and Care Excellence, 2013). Bully victims, who face the worst outcomes as they progress to adulthood, may also require broader assessment for underpinning risk factors such as family victimisation, maltreatment or trauma followed up with appropriate trauma-informed treatment (Duncan, 1999).

Prevention of self-harm

Self-harm is rare at this age but is generally a means to release emotional pressure when this becomes overwhelming. As such it is closely linked to difficulties in regulating emotions. Depression (commonly associated with self-harming) is rare at this age.

Effective programmes have not yet been developed to prevent self-harming behaviours in children and young people (Khan, *et al.*, 2015). There may also be concern in schools about talking about self-harm during primary school years due to some evidence of a risk of ‘contagion and mimicry’ with this type of activity. There are, however, some signs that self-harm may be increasing during teenage years (and particularly by the time young women reach mid to late adolescence) (McManus, *et al.*, 2009). Greater clarity will emerge from the planned child and adolescent psychiatric morbidity survey. Given that self-harming is distressing, highly damaging and costly, this may be an area requiring urgent continuing research and development.

If self-harming has increased, more research may be required to investigate effective interventions. There may be a particular case for longer term high quality follow-up of outcomes for children receiving Whole School SEL and counselling interventions, with particular attention paid to longer term impact on mental health and later risk of self-harming.

Evidence based parenting interventions

Although there is robust evidence of the damaging effect of early starting behavioural difficulties on children’s life chances and mental health prospects (see Figure 1 on page 3), there is also a good indication of what works to improve the mental health of these children and lower future risks. NICE-recommended positive parenting programmes (Triple P, Incredible Years or Webster Stratton, Strengthening Families, Strengthening Communities, Parent Management Training - Oregon model, Families and Schools Together etc) must be effectively implemented to have the best chance of producing positive change. For example, this means ensuring that they:

- Are targeted at families who need them;
- Are facilitated by well trained and supervised staff;
- Place a premium on keeping parents engaged.

These programmes have an excellent record of helping children move back into healthy behavioural ranges. They help improve children’s self-regulation, settle behaviour and reduce family stress through teaching positive parenting techniques. They also have a proven ability to reduce parental mental health problems. They have been successfully tested with diverse ethnic groups (National Institute for Health and Care Excellence, 2013; Centre for Mental Health, 2012).

Programmes work best when targeted at parents of children with the highest levels of need (Centre for Mental Health, 2012). There is some evidence that gains are sustained over time; however, more research is required extending the length of follow up for children and families who have benefitted from these programmes. Programmes are exceptionally good value producing savings over time of at least £3 for every pound invested. Initial savings benefit schools (who often have to employ more frontline resources to manage children with challenging behaviour). The greatest savings occur later on in the justice system. Savings also accrue for social care and for the NHS (Parsonage, *et al.*, 2014). One of the challenges with such programmes is that commissioners who benefit most do not currently invest in them.

Centre for Mental Health found that there was rarely sufficient delivery of NICE-recommended parenting provision to meet likely levels of clinical need for local children (Centre for Mental Health, 2012). Since the last audit of provision in 2010, it is also difficult to assess the extent to which continuing cuts to Local Authority provision and to Children’s Centres have further compromised availability. When such programmes are available, they are also frequently not targeted at those with the most severe needs who can benefit most from this type of help (Centre for Mental Health, 2012).

Some charities have attempted to extend the reach of such services particularly through Troubled Families and school contracts. In Scotland, there is a major initiative to make parenting programmes more systematically available in nursery settings for children showing vulnerability. Children are routinely screened to assess their wellbeing as part of health visitor and nursery activity with encouragement to link up with support for those in clinical ranges (NHS Education for Scotland, 2014).

Individual parenting programmes

One-to-one positive parenting support programmes such as 'Helping The Non-Compliant Child' (which involves a therapist observing a parent and child through a two-way mirror and coaching the parent) are also effective despite generally higher delivery costs (Washington State Institute for Public Policy, 2015; National Institute for Health and Care Excellence, 2013). These programmes are best reserved for the small percentage of children and families who are least likely to engage with group programmes, have complex and multiple needs, and struggle most engaging with group programmes (Centre for Mental Health, 2012).

Children with attention deficit hyperactivity disorder (ADHD)

Only about a third of children diagnosed with ADHD have this condition on its own, with most of the remaining two-thirds also having some form of conduct disorder (Centre for Mental Health, 2014). For these children, NICE-recommended parenting programmes should form part of wider evidence-led approaches focusing on broader environmental risks surrounding a child (such as classroom strategies, medication etc.) (National Institute for Health and Clinical Excellence, 2008; Khan, *et al.*, 2015). Behavioural Parent Training (BPT) for children with ADHD also shows some promise in supporting parents to work with teachers through developing psycho-education and behaviour management techniques (Washington State Institute for Public Policy, 2015).

Children with anxiety

Various forms of Cognitive Behavioural Therapy (CBT) have demonstrated effectiveness in reducing anxiety in children and young people aged 7-12 years. Examples of effective programmes include Coping Cat and the Australian version Coping Koala.

CBT for anxiety is based on the idea that anxiety is a learned response that can be unlearned. It addresses problematic thoughts and behaviours related to anxiety. Strategies include understanding and managing negative thoughts, skills development, managed exposure to triggers for anxiety, role-playing, positive reinforcement and relaxation training.

Support can be delivered through group programmes involving children or alternatively involving parents. These interventions are good value and effective. Estimated savings range from £10 (for parent groups) to £30 (for child groups) for every pound invested (Washington State Institute for Public Policy, 2015).

Skills can also be delivered through one to one sessions with children or with parents (although the latter appears less effective). One to one CBT with children of this age results in improvements producing savings of around £6 for every pound invested.

The Coping Cat CBT programme has recently been piloted in the UK for children with both autism and anxiety with promising results (Washington State Institute for Public Policy, 2015).

Children with depression symptoms

Depression is rare among 5 to 10 year olds. However, a group programme targeted towards children on the cusp of this age group (aged ten and eleven) with depressive symptoms has produced strong evidence of ability to reduce symptoms. It is good value and has been shown to produce measurable savings of around £8 for every pound invested (Washington State Institute for Public Policy, 2015).

Children who have experienced trauma

Trauma can result from one event, multiple events, or a series of them. These events can cause children to see the world as dangerous and can alter their ability to function. A child may experience anxiety, fear of death, panic, powerlessness, prolonged sleep problems, anger and deep sadness. When trauma is a result of violence perpetrated by a parent/care-giver they trust, it becomes overwhelming and can cause a child to be in a constant state of anxiety. This, of course, interferes with the child's ability to trust or to invest in and sustain relationships.

After experiencing trauma, a child may have recurring nightmares, flashbacks, cope by avoiding things associated with the disturbing experience or may exhibit angry or challenging behaviour in the face of any stressful situation triggering a reminder.

There are currently few proven interventions for trauma in children. One intervention showing measurable improvements for children in this age group with symptoms of trauma is Eye Movement Desensitisation and Reprocessing (EMDR). EMDR is effective and well supported by research evidence for treating children with symptoms accompanying Post-Traumatic Stress Disorder (PTSD) and associated feelings of guilt, anger, depression and anxiety. The goal is to reduce the long-lasting effects of distressing memories through controlled exposure and by developing more adaptive coping mechanisms. The therapy uses an eight-phase approach that includes having the child recall distressing images while receiving one of several types of alternative sensory input, such as side to side eye movements or hand tapping.

Again, these programmes show good effectiveness and cost effectiveness. They are noted to be more effective with simple rather than complex trauma suggesting that there is real benefit in intervening early before a child begins to experience an accumulation of complex adversity or before risk of multiple victimization (Washington State Institute for Public Policy, 2015).

Children with eating disorders

Although eating disorders span a spectrum, most children do not develop conditions that meet the criteria for an eating disorder until teenage years. Despite the anecdotal concern over girls developing unhealthy attitudes about body image at an earlier age than in the past, few programmes have been targeted at this age group. Universal prevention programmes have not so far been able to demonstrate effectiveness in addressing risk factors or in preventing severe problems later on (Pratt & Woolfenden, 2002). This is an area for further research and development.

Children with autism

There is generally poorer quality evidence of what works to support children and young people with autism mainly due to insufficient investment in higher quality research. There is emerging evidence that interventions focusing on social communication and developing social skills have positive outcomes for children with autistic conditions. Interventions facilitated by speech and language therapists and involving the carer/parent and child show some promise in improving social communication of young children (NICE, 2013). For young children there is also evidence that peer-mediated play sessions (where a child with autism plays with a typically developing peer) may improve social interaction with other peers (NICE, 2013). More investment is required in testing out promising programmes to see if encouraging results can be replicated consistently.

Seeking help

Most parents with a child aged 5-15 who meets the criteria for a common mental health diagnosis will seek professional help and advice for their children (Green *et al.*, 2005). This ranges from 73% for parents with a child with diagnosable emotional difficulties to 95% for a child with hyperactivity. Most will approach a teacher; the remainder GPs. A few also approach other members of their family. For most common diagnosable conditions, only around a quarter of children and young people get the help that they need (Green, *et al.*, 2005). Furthermore, one study indicates that on average there is a ten year delay between first experience of symptoms and getting help (Wang, *et al.*, 2007) which is worrying given evidence about the critical importance of intervening early to improve chances of recovery (Patel, *et al.*, 2007; Knapp, *et al.*, 2011).

Parents whose children had emotional problems were less likely to identify that their child had a diagnosable mental health difficulty: many sought help believing that symptoms were associated with physical health, developmental or behavioural problems. Lower identification rates are assumed to be because emotional problems are more subtle in presentation and less readily observable than other conditions such as hyperactivity (Green, *et al.*, 2005).

Children with conduct problems face similar challenges getting the help they need but for different reasons. Three quarters of parents of a child with a diagnosable conduct problem approach a professional (mainly teachers or less frequently a GP) with concerns about their child's behaviour, and two thirds correctly recognised that their child might have a mental health problem. Despite this, only a quarter of children received help (Green, *et al.*, 2005).

In 2010, Centre for Mental Health investigated some of the drivers for this lack of access to appropriate and early help for children with childhood conduct problems. Many professionals and some parents tended to perceive children with behavioural difficulties as predominantly naughty rather than seeing behaviour as a communication of distress

or 'need'. This prevented, or led to delays in, accessing help. Access was not helped by some specialist CAMHS having explicit exclusion criteria for children with behavioural problems (Centre for Mental Health, 2012). There appeared an apparent reluctance in some local areas to accept that severe and persistent behavioural problems were in fact a diagnosable mental health condition in their own right, even though they are our most common and life-damaging childhood mental illness (Green, *et al.*, 2005).

Finally, access was hampered by the complexity of local pathways. Many evidence based interventions for these children were not provided by specialist CAMHS but commissioned instead by local authorities. Neither parents, teachers, nurses nor GPs understood the maze-like pathways to get help and many areas lacked a clear central gateway for help when a child had worrying yet unclear needs (Khan, 2014). Furthermore, systems often felt fragmented so that if a parent got turned down by one agency there was no follow-up action to link families up with alternative sources of help. This often meant that families, children and young people found themselves ricocheting for many months around the system (Department of Health, 2015). Some of these barriers have been highlighted by the recent national CAMHS Taskforce and there is now a national ambition to improve access to services through the development of Transformation Plans (Department of Health, 2015).

Almost all parents of a child with ADHD sought professional help because they were concerned about their child's emotions, concentration or behaviour and most recognised that their child had one if not more co-existing mental health difficulties. Children with hyperactivity were most likely to receive specialist treatment through mental health services (52%) and special educational services (37%). Nearly half also accessed primary care services such as GPs, nurses and paediatricians (Green, *et al.*, 2005).

Almost all parents of children with autism approached professionals for help and a larger proportion of these children were referred on

to more specialist help. For example, around half of children with autistic conditions had accessed special educational needs services in schools or specialist mental health services. Over a third also accessed specialist physical health services such as community paediatricians (Green, *et al.*, 2005).

Eating disorders appeared rare in this age group in the 2004 survey. Because of the very small numbers of children with these conditions, there is little evidence on the extent to which they or their parents either seek or receive help.

Research priorities

Generally, there has been insufficient investment in mental health research compared with other areas of health. More research and development should be encouraged in child mental health in the following areas for this age group:

- Research and development into effective anti-bullying initiatives, self-harm prevention programmes and eating disorder prevention programmes, including good quality longitudinal tracking of outcomes for children benefitting from interventions. Research into eating disorders is increasingly pinpointing heritable risks as well as environmental risks driving the development of these illnesses. There is scope, therefore, to develop and test targeted programmes for higher risk groups in the future and evaluate the impact of programmes through longitudinal follow-up.
- There is a need for more analysis of birth cohort data unpicking those factors promoting resilience in children at risk of poor mental health (e.g. Centre for Mental Health is continuing to work with the Centre for Longitudinal Studies in this area of investigation).

Key messages

- School is a unique and critical environment touching the lives of almost all children which has the ability either to build on or redress early life experiences.
- If schools are mental health-promoting environments (adopting a whole school approach, proactively monitoring mental health and wellbeing, addressing bullying effectively, encouraging healthy relationships and school connectedness, having good links with effective local specialist support and parenting programmes, commissioning good quality counselling services and social and emotional learning programmes), they can help mobilise critical protective factors which can counter earlier experiences, reduce toxic cumulative risk and build children's resilience.
- School is one of the few settings where there are proven effective interventions targeting the entire school population which are effective in reducing children's chances of developing future mental health difficulties.
- Where schools are not psychologically informed environments (with poor management of bullying, dismissive of poorly connected/attached children, insufficient focus on children's wellbeing, poor linkage to support), children's mental health not only suffers but so does their attainment.
- Because of the length of time children spend in schools and the number of parents approaching teachers for help, these settings have considerable potential to pick up children's poor mental health early.

Missed opportunities

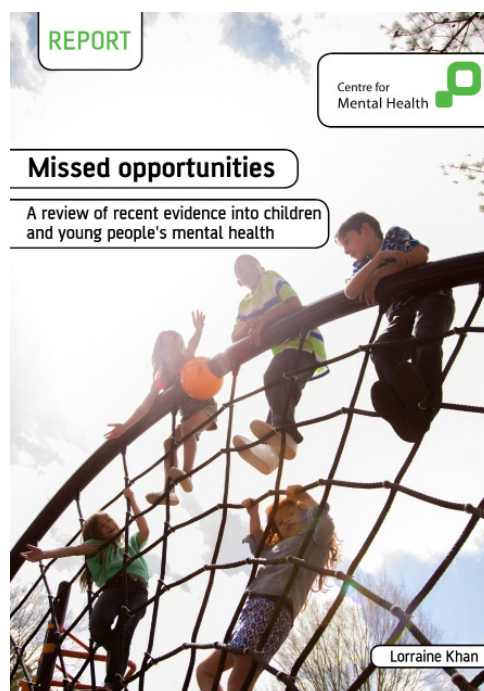
This is a chapter from the report **Missed opportunities: a review of recent evidence into children and young people's mental health** by Lorraine Khan. For the full report, or the reference list, please visit www.centreformentalhealth.org.uk/missed-opportunities

Photograph: Pamela Moore

£10 where sold

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here: www.centreformentalhealth.org.uk

© Centre for Mental Health, 2016
Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.



Centre for
Mental Health



Realising a better future

Centre for Mental Health

134-138 Borough High Street, London SE1 1LB

Tel 020 7827 8300

Fax 020 7827 8369

www.centreformentalhealth.org.uk

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019.