DISCUSSION PIECE

A CRITICAL REFLECTION ON THE CURRENT SITUATION WITH CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH PROVISION

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Concerns over mental health (MH) provision for children and young people (CYP) has gained momentum since being a focus of the Department of Health's UK public health policy in 2000. Over the years, the attention on CYP MH has increased due to the degree of emotional and behavioural issues reported, and demand for improvements in provisions. This increased incidence in CYP MH wellbeing issues leaves us pondering questions as to why and what we need to do about it. This review explores how problems have arisen and how we might successfully respond to these challenges.

Over the last 20 years, children, and young people's (CYP) mental health (MH) has noticeably changed alongside the emphasis and importance placed on it. In 1999, the Great Britain Child Mental Health survey found a total of 9.6 per cent of all CYP were understood to be fitting the criteria for MH disorders, though less than 35 per cent of children with diagnosable MH disorders were being identified (Meltzer et al., 2000). In the previous year, a report introducing the impact of adverse childhood experiences (ACEs) on future MH issues was published (Felitti et al., 1998). The report found a compelling correlation between physical, emotional, and sexual abuse, neglect, household dysfunction, parental mental illness, household violence, substance abuse and having an incarcerated relative. Being exposed to four or more of these higher intensity risk factors during the years of childhood accelerates incidence of MH and death in adulthood. ACEs have since become recognised as a key MH determinant, and used to outline the systematic support CYP experiencing ACEs might need (British Psychology Society (BPS), 2020). Research looking at retrospective and probable causes of MH has shown that most adult MH disorders begin in childhood and adolescence (Department of Health and Department for Education, 2017; Dhanak et al., 2020; Merikangas et al., 2009; Thomas et al., 2016). As such, we need to understand these risk factors and their frequency

(Merikangas et al., 2009) in relation to the increasing MH problems with CYP but more importantly how to address and support them as soon as possible.

The Great Britain Child Mental Health survey of 2017 (National Health Service, 2018) reported that the incidence of CYP with MH disorders had increased from 9.6 per cent in 1999 to 12.8 per cent in 2017; it was estimated that one in eight CYP had a diagnosable MH condition (BPS, 2017a). In the same report, a grouping categorisation was introduced that covered the four major strands of CYP MH: emotional, behavioural, hyperactivity and other less common disorders. Research suggests that among 5-to-10-year-olds, 10 per cent of boys and five per cent of girls are dealing with a MH concern, and of the 11-to-16-year-old category, it is 13 per cent and 10 per cent respectively (Murphy & Fonagy, 2013). Of all the categories now used to distinguish CYP MH, emotional problems are currently seen to be the most dominant (National Health Service, 2018). This increase in emotional issues is equally evident in both boys and girls and is having a serious effect on children now but could also impact negatively across their lifespan (Longfield, 2021).

Life appears to be becoming more difficult for CYP to thrive, and growing up brings differing degrees of trauma for some CYP (BPS, 2020). There is also a higher incidence of MH problems with CYP in particular population groups, including those from lower socio-economics status and/or ethnic minority backgrounds, and those living in more rural or isolated locations (Dray et al., 2015). As previously mentioned, a higher prevalence of ACEs in children could also explain why we are seeing an upturn in mental health vulnerabilities (BPS, 2020). If factors such as poverty, social and economic inequality and discrimination are creating these MH problems for CYP, and are left unchanged, then we are going to have to keep rectifying the issue rather than preventing it (Ohare, 2018). Therefore, we need to look more closely at what is causing this upturn in MH issues and have a better understanding of the problems that are seen as detrimental to emotional health and psychological wellbeing (World Health Organisation, 2008).

In more serious traumatic life events, CYP may experience double trauma as they can lose other resilience promoting factors too, such as the loss of support from parents who are dealing with their own trauma (Danese et al., 2020). This can make CYP and their families increasingly vulnerable to MH problems, and needs essential support quickly. However, guidance for parents navigating these challenges is also lacking, along with speedy and effective support for CYP MH (Vostanis et al., 2010). This can lead to a further vulnerability among parents and CYP when accessing the specialist support they need (Anderson et al., 2019), and can create further problems.

Being unable to access MH support when needed exacerbates the initial MH concern with further complications. These include increased emotional distress, social isolation and, in worst cases self-injury and risks of suicide (Dhanak et al., 2020). These issues are estimated to affect 75 per cent of CYP who wait so long that their condition often worsens, or they are tragically unable to access any treatment at all (Local Goverment Association, n.d.). CYP experiencing MH difficulties are also much more likely to face increased problems with social experiences, health (e.g. asthma, diabetes, anxiety disorders (Merikangas et al., 2009), and academic and financial progress (Soneson et al., 2020). The longer-term economic costs connected to untreated CYP's MH disorders include medical expenses, societal burdens on the judicial and social services systems (Merikangas et al., 2009) and intergenerational transfer of psychological, social, emotional, and behavioural issues (Hancock et al., 2013). Gaining a better understanding of the

problems that are seen as detrimental to emotional health and psychological wellbeing and the pressure that this puts on current support services is important in helping to bring about the desired changes.

The demand on Child and Adolescent Mental Health Services (CAMHS) has taken its toll over the years. The system is bottlenecked and struggling to meet the needs due to an estimated 33 per cent increase in referrals over the last seven years (Local Goverment Association, n.d.). The same report also concluded that specialist services are turning away 25 per cent of CYP referred to them by their GPs or teachers for treatment and less than a third of the 338,000 children that were referred to CAMHS in 2017 received treatment within the year. This was also supported in the NHS Mental Health of Children and Young People in England Report (National Health Service, 2018) which stated that 48.5 per cent of CYP struggling with MH had initially approached a teacher for support. Of these, 25.2 per cent received specialist MH support from CAMHS however roughly a quarter of CYP with MH disorders did not receive supportive contact from anyone, leaving their MH issues to remain unaddressed.

As schools appear to be the place where many British CYP first seek MH support, they may well be one answer to improving the identification of MH conditions (Anderson et al., 2019; Soneson et al., 2020). They are also the most global setting with the highest degree of contact hours and positive relationships with CYP and families during a time when MH issues are most likely to begin (Department of Health and Department for Education, 2017). However, this expectation could be seen to be an increased burden on an already strained education system, which posits the question as to whether they should be shouldering this responsibility at all (Nadeem et al., 2016).

The impact of CYP MH is one of the most complex issues that British society is dealing with today (BPS, 2017a), and the greatest impact, outside of the family home, is experienced by teachers and the schools' population (BPS 2017b). In the 2017 BPS briefing paper 'Mental health support teams: How to maximise the impact of the new workforce for children & young people', 94 per cent of teachers with five or more years of experience reported an increase in MH complexities with the CYP that they were teaching now compared to when they started (British Psychological Society, 2017a). In the same report, it was conveyed that over a third of teachers do not feel confident in supporting CYP with such complex issues. Nevertheless, due to teachers knowing their CYP as well as they do, they are more likely to notice emotional and behavioural changes. Hence, a system that relies on teachers identifying MH concerns (Anderson et al., 2019) could be a valuable systematic approach to screening and providing effective MH support as quickly as possible. Recognising and understanding the reality of CYP MH as early as possible could also help reduce further pressures placed up on them in school. CYP dealing with MH issues are often behind academically (44 per cent), recognised to have special educational needs (33 per cent), have significantly lower attendance (43 per cent), and are more vulnerable to exclusion (12 per cent; Vostanis et al., 2010). This reinforces the greater responsibility and pressure that school staff could feel if CYP's MH and emotional wellbeing falls to them (Nadeem et al., 2016), especially with communication and service pathways to CAMHS support also lacking (Vostanis et al., 2010). Training across services could possibly be a solution to this issue. To help manage these concerns in the past, CAMHS have delivered programmes to school staff. However little opportunity has been given for schools to educate CAMHS workers on the impact MH issues have in the educational setting (Vostanis et al., 2010) and this is not mentioned in a recent BPS briefing paper

focusing on incorporating mental health support teams into schools, suggesting that cross-service training is still not seen to be a priority (BPS, 2017a).

CYP with MH concerns need to be seen quickly by experts who understand the system and understand the school demands. A collaborative and sustainable approach needs to be in place for all stakeholders; a system that can bind the two models together with the prioritised goal of improved mental health provision for CYP (Soneson et al., 2020). By employing applied psychologists in schools to work directly with CYP presenting with MH matters and work closely with staff, a more resilient and supportive MH philosophy could be developed in schools (BPS, 2017a). This method could also incorporate a strong, positive psychological philosophy that underpins the school ethos and supports the MH and well-being of CYP and staff. This approach could be argued to address three possible needs with effective outcomes for CYP's MH. Firstly, there is a need for staff reflective guidance, training and skills-based action, plus effective psychologically-informed practices (e.g. cognitive behavioural therapy, positive psychology, and neuroscience) that could be delivered quickly to children who have developed MH symptoms whilst in school (BPS, 2020). Secondly, a combination of insight plus action could be the precursor that drives positive change for the full school community and a philosophy that could also be extended to the family. Thirdly, by scaffolding and supporting the whole household, the cross directional flow and negative impact of MH could be reduced (Hancock et al., 2013).

This paper has raised two issues that need to be considered to help to improve CYP's MH. Firstly, we need to look deeply at the current issues and understand the impact on CYPs' MH and secondly, we need an effective service to support them as quickly as possible to prevent further long-term complications. Although some suggest that focusing on children in school with emotional and behavioural issues is the tip of the iceberg (BPS, 2020), it is highly evident that we need to start somewhere. With an effective psychological model integrated into the school system, there is an opportunity to start making small and positive changes for CYP MH now, which could lead to bigger and better changes across the lifespan of individuals and future generations.

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REFERENCES

Anderson, J.K., Ford, T., Soneson, E. et al. (2019). A systematic review of effectiveness and cost-effectiveness of school-based identification of children and young people at risk of, or currently experiencing mental health difficulties. *Psychological Medicine, 49*(1), 9–19. https://doi.org/10.1017/s0033291718002490

British Psychology Society (2017a). *Mental Health Support Teams: How to maximise the impact of the new workforce for children and young people.* www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Briefing%20Paper%20-%20Mental%20Health%20Support%20Teams.pdf

British Psychological Society (2017b). *Children and young people's mental health (CYPMH): Schools and colleges.* www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-%20Files/Briefing%20Paper%20-%20CYPMH%20Schools%20and%20Colleges.pdf

British Psychological Society (20 October 2020). *BPS responds to NHS report on The Mental Health of Children and Young People in England in 2020*. www.bps.org.uk/news-and-policy/bps-responds-nhs-report-mental-health-children-and-young-people-england-2020

Danese, A., Smith, P., Chitsabesan, P. & Dubicka, B. (2020). Child and adolescent mental health amidst emergencies and disasters. *British Journal of Psychiatry, 216*(3), 159–162. https://doi.org/10.1192/bjp.2019.244

Department of Health and Department for Education (2017). *Transforming Children and Young People's Mental Health Provision: A Green Paper*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

Dhanak, D., Thackeray, L., Dubicka, B. et al. (2020). Adolescents' experiences of brief psychosocial intervention for depression: An interpretative phenomenological analysis of good-outcome cases. *Clinical Child Psychology and Psychiatry, 25*(1), 106–118. https://doi.org/10.1177/1359104519857222

Dray, J., Bowman, J., Wolfenden, L. et al. (2015). Systematic review of universal resilience interventions targeting child and adolescent mental health in the school setting: review protocol. *Systematic Review, 4*(1), 12–29. https://doi.org/10.1186/s13643-015-0172-6

Felitti, V.J., Anda, R.F., Nordenberg, D. et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults the Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine, 14*(4), 245–258. https://doi.org/10.1016/S0749-3797(98)00017-8

Hancock, K.J., Mitrou, F., Shipley, M. et al. (2013). A three generation study of the mental health relationships between grandparents, parents and children. *BMC Psychiatry, 13*(1), 1–11. https://doi.org/10.1186/1471-244X-13-299

Local Goverment Association (n.d.). CAMHS – facts and figures. https://www.local.gov.uk/about/campaigns/bright-futures/bright-futures-camhs/child-and-adolescent-mental-health-and

Longfield, A. (2021). *The state of children's mental health services, 2020.* www.childrenscommissioner.gov.uk/wp-content/uploads/2021/01/cco-the-state-of-childrens-mental-health-services-2020-21.pdf

Meltzer, H., Gatward, R., Goodman, R. & Ford, T. (2000). *The mental health of children and adolescents in Great Britain Editorial policy statement Information services.* www.dawba.info/abstracts/B-CAMHS99_original_survey_report.pdf

Merikangas, K.R., Nakamura, E.F. & Kessler, R.C. (2009). Epidemiology of mental disorders in children and adolescents. *Dialogues in Clinical Neuroscience, 11*(7), 7–20. https://doi.org/10.31887/dcns.2009.11.1/krmerikangas

Murphy, M. & Fonagy, P. (2013). Mental health problems in children and young people. In C. Lemer's *Annual Report of the Chief Medical Officer 2012: Our children deserve better: Prevention pays* (1–13). https://dera.ioe.ac.uk/18694/7/33571_2901304_CMO_All_Redacted.pdf

Nadeem, E., Santiago, C.D., Kataoka, S.H. et al. (2016). School personnel experiences in notifying parents about their child's risk for suicide: Lessons learned. *Journal of School Health, 86*(1), 3–10. https://doi.org/10.1111/josh.12346

National Health Service (2018). *Mental health of children and young people in England, 2017: Summary of key findings.* https://files.digital.nhs.uk/A6/EA7D58/MHCYP%202017%20Summary.pdf

Ohare, D. (8 Feburary 2018). *Children's mental health: We're still not looking far enough upstream.* www.bps.org.uk/blogs/daniel-ohare/children's-mental-health-we're-still-not-looking-far-enough-upstream

Soneson, E., Howarth, E., Ford, T. et al. (2020). Feasibility of school-based identification of children and adolescents experiencing, or at-risk of developing, mental health difficulties: a systematic review. *Prevention science, 21*(5), 581. https://doi.org/10.1007/s11121-020-01095-6

Thomas, S., Jenkins, R., Burch, T. et al. (2016). Promoting mental health and preventing mental illness in general practice. *London Journal of Primary Care, 8*(1), 3–9. https://doi.org/10.1080/17571472.2015.1135659

Vostanis, P., Taylor, H., Day, C. et al. (2010). Child mental health practitioners' knowledge and experiences of children's educational needs and services. *Clinical Child Psychology and Psychiatry, 16*(3), 385–405. https://doi.org/10.1177/1359104510366283

Wells, J., Barlow, J. & Stewart-Brown, S. (2003). A systematic review of universal approaches to mental health promotion in schools. *Health Education, 103*(4), 197–220. https://doi.org/10.1108/09654280310485546

World Health Organisation (2008). *General Social Determinants of Health.* https://apps.who.int/iris/bitstream/handle/10665/206363/B3357.pdf