Handout

Triggers for referral: loss or separation

Warning signs that a child may need specialist help following loss or separation

Grief is very complex and diverse. Everyone responds differently and the length of time for individuals to integrate varies. However, if certain reactions continue for some time and appear to be increasing rather than diminishing, action is needed and the help of specialist services may need to be considered. Obviously, it is helpful to discuss concerns with foster carers or adoptive parents in order to view the whole picture.

The following warning signs should not be seen in isolation but should be taken together with the assessment and what else is happening in the child's life.

- Avoidance of friends and family
- Always tired and ill
- School problems/difficulties
- Self-destructive behaviour, desire to die
- Persistent feelings of worthlessness and guilt
- Continual denial of the reality of the death
- Experiencing prolonged depression/anxiety
- Aggressive behaviour
- Reliance on drugs/alcohol
- Eating disturbances

(Open University (2001) K260 course Death and Dying: Workbook 4, Bereavement: Private Grief and Collective Responsibility. Milton Keynes: Open University)

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Handout for professionals

Working with a child who is experiencing grief

Help foster carers or adoptive parents to support the child by offering books or leaflets about grief. Carers may feel more comfortable in sharing books with children, as they can be less threatening than direct talk. However, ensure that the carer is comfortable with their own feelings first.

Check out the child's understanding before you or the carers launch into giving unnecessary information that may be inappropriate for their age group. Be honest. If you don't know the answer, say so.

Reassure carers that it is OK to allow children to see them cry. It gives the child permission to show their feelings and allows the child to comfort as well as be comforted.

Suggest that carers encourage the child to use poems or drawings to help the child to express feelings. Suggest that they make a memory box, adding photographs and treasured items of the person who has died.

Carers should not feel that they have to do all the work themselves. A teacher, a school nurse or a relative may be able to offer support or an opportunity to listen to the child.

Discuss supportive measures for the carers. Who will they talk to? Ensure they have contact telephone numbers of agencies/charities that can offer support and advice.

Be aware of the child's culture and beliefs.

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Promoting Children's Mental Health Within Early Years and School Settings

Introduction

This guidance has been written for Local Education Authorities, schools, early years settings and Child and Adolescent Mental Health Services. It has been produced as a result of increasing recognition of the importance of promoting all children's mental health and emotional well-being and the importance of working together to promote this.

Increasing numbers of children are experiencing mental health problems. A recent ONS survey showed that 10% of children aged between 5–15 experience clinically defined mental health problems. This guidance offers pointers and examples of good practice in the area of the early identification and interventions for children and young people experiencing mental health problems in pre-school and school settings.

Mental health is about maintaining a good level of personal and social functioning. For children and young people, this means getting on with others, both peers and adults, participating in educative and other social activities, and having a positive self-esteem. Mental health is about coping and adjusting to the demands of growing up. It does not all happen at one point in time, and appears to result from an interactive process to which we can all contribute, based on the child's environmental, social and cultural context[i].

This guidance is designed to help teachers and others, working alongside mental health professionals, to promote children's mental health and to intervene effectively with those children experiencing problems. It forms part of a joint approach with the Department of Health to promote health issues in schools and other mainstream settings. It is part of a wider strategy currently being developed through the NHS plan, the Children's Taskforce and the cross-cutting Children and Young People's Unit. This will improve the services to children and young people and their families and ensure that all children have the opportunity to fulfil their potential.

The case studies referred to in the text are taken from interesting examples of work that have come to our attention. Some, but by no means all, of the case studies have been evaluated. Nevertheless, they provide a range of models, which are being developed to address the mental health needs of children within early years and school settings. The examples within the text of individual children who are experiencing difficulties, do not relate to particular children, but are intended as helpful illustrations of the type of difficulties that children may encounter.

Section 1

Questions about Mental Health

1.1 What is Mental Health?

Children who are mentally healthy have been defined as having the ability to:

- develop psychologically, emotionally, intellectually and spiritually;
- initiate, develop and sustain mutually satisfying personal relationships;
- use and enjoy solitude;
- become aware of others and empathise with them;
- play and learn;
- develop a sense of right and wrong; and
- resolve (face) problems and setbacks and learn from them[ii].

Some children experience a range of emotional and behavioural problems that are outside the normal range for their age or gender. These children and young people could be described as experiencing mental health problems or disorders.

Mental health professionals have defined the problems that children and their families can be faced with as follows:

- emotional disorders, e.g. phobias, anxiety states and depression that may be manifested in physical symptoms;
- conduct disorders, e.g. stealing, defiance, fire-setting, aggression and anti-social behaviour;
- hyperkinetic disorders e.g. disturbance of activity and attention;
- developmental disorders e.g. delay in acquiring certain skills such as speech, social ability or bladder control, primarily affecting children with autism and those with pervasive development disorders;
- attachment disorders, e.g. children who are markedly distressed or socially impaired as a result of an extremely abnormal pattern of attachment to parents or major care-givers;
- eating disorders, e.g. pre-school eating problems, anorexia nervosa and bulimia nervosa;
- habit disorders e.g. tics, sleeping problems, soiling;
- post-traumatic stress syndromes;

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- somatic disorders e.g. chronic fatigue syndrome; and
- psychotic disorders e.g. schizophrenia, manic depressive disorder, drug-induced psychosis[iii]. *(For a fuller description of these terms see Section 4)*

Many of these problems will be experienced as being mild and transitory nuisances to the child and their family, whereas others will have serious and longer lasting effects.

When a problem is particularly severe or persistent over time, or when a number of these difficulties are experienced at the same time, children are often described as having mental health disorders.

1.2 Mental Health or Emotional and Behavioural Difficulty?

The terms mental health problems and mental health difficulties are not precise – with definitions ranging from the highly categorised still employed by some health service professionals, to those based on more descriptive terms which are prevalent in schools and school-support services.

Children experiencing problems (and predominately externalising problems) in schools have tended to be defined as having emotional and behavioural difficulties. EBD is a term to be understood within an educational context, to describe a range of difficulties that children might experience as a result of adverse experiences in the early years, difficult family relationships or ineffective behaviour management or means of engaging children effectively within the school.

Such a definition will include many children who experience or are at risk of experiencing mental health problems; such as those who are so withdrawn and anxious that it is significantly impacting on their ability to learn, or those whose behaviour is so extreme they are not able to sit and concentrate. However, not all children with mental health problems will necessarily have special educational needs. Some children, for example those who are extremely anxious and isolated, may be in need of additional help and support within the school in order to help them overcome their difficulties. Other children, for example a child with an eating disorder, may be in need of support outside school, but which the school with an effective pastoral and/or counselling service can help the child access.

For other children however, their behavioural difficulties, which often have a significant emotional element to them, may be so intertwined with their inability to concentrate, to learn and to get on with their peers, that an approach which does not include attention to the educational alongside their emotional, social and behavioural needs will fail to provide the range of support that they need. Such children may be defined as having an emotional and behavioural problem when seen within an educational context. By a medical practitioner, however, the same child may be defined as having a conduct disorder, a mental health term used to describe children with overly oppositional or defiant behaviour.

The challenge is to find ways in which the different approaches and frameworks and professionals can operate effectively together. In many pre-schools and schools there is currently a great deal of positive practice in developing such work – this is often not without difficulties and compromises amongst all those involved – often requiring the development

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of new understandings and ways of working between the different professionals. The gains for all, however – those children experiencing problems, their peers, teachers and other school staff, often the school as a whole – ultimately outweigh the difficulties in initially developing this work.

1.3 What are the Causes of Mental Health Problems in Children and Young People?

Evidence has shown that it is possible to identify the factors that have an impact on children's mental health. Certain individuals and groups are more at risk of developing mental health problems than others, and these risks are located in a number of areas – risks specific to the child, to their family, their environment and life events. There are a range of factors in children's and young people's lives which can result in them being at increased risk of developing mental health difficulties:

- loss or separation – resulting from death, parental separation, divorce, hospitalisation, loss of friendships especially in adolescence, family breakdown that results in the child having to live elsewhere;
- life changes, e.g. birth of a sibling, moving house, changing schools; and
- traumatic events – abuse, violence, accidents, injuries, war or natural disaster.

Other children, against all the odds, develop into competent, confident and caring adults. An important key to promoting children's mental health is therefore an understanding of the protective factors that enable children to be resilient.

RISK FACTORS

Risk factors are those which increase the *probability* of a child developing a mental health problem. There is a complex interplay between the range of risk factors in the child's life, their relationship with each other and more positive resilience factors. Risk factors are cumulative. If a child has only one risk factor in their life, their probability of developing a mental health problem has been defined as being 1–2%. However, with three risk factors it is thought that the likelihood increases to around 8%; and with four or more risk factors in their life this increases to 20%.

We know therefore that the greater the number of risks, and the more severe the risks, the greater the likelihood of the child developing a mental health problem.

RISK FACTORS IN THE CHILD

Certain children have particular vulnerabilities, which have to be understood in relation to their 'assets' – their resiliences. For example, children who have a 'difficult temperament' and who are less likely to be able to adapt themselves to new social situations are more at risk of developing mental health problems than their peers.

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Risk Factors in the Child:

- Specific learning difficulties
- Communication difficulties
- Specific developmental delay
- Genetic influence
- Difficult temperament
- Physical illness especially if chronic and/or neurological
- Academic failure
- Low self-esteem

Risk Factors in the Family:

- Overt parental conflict
- Family breakdown
- Inconsistent or unclear discipline
- Hostile or rejecting relationships
- Failure to adapt to a child's changing needs
- Physical, sexual or emotional abuse
- Parental psychiatric illness
- Parental criminality, alcoholism or personality disorder
- Death and loss – including loss of friendship

Risk Factors in the Community:

- Socio-economic disadvantage
- Homelessness
- Disaster
- Discrimination
- Other significant life events

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RESILIENCE FACTORS

> *'Resilience seems to involve several related elements. Firstly, a sense of self-esteem and confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem solving approaches'.* [iv]

Research suggests that there is a complex interplay between risk factors in children's lives, and promoting their resilience, and that as disadvantage and the number of stressful life events accumulate for children or young people, more protective factors are needed to act as a counterbalance.

As with risk factors, those features that serve to reduce the impact of risk or promote resilience relate to characteristics within the child, family or wider community and can include any combination of these factors.

RESILIENCE FACTORS IN THE CHILD

Children who are able to establish a secure attachment to their parents in the first year of life are better able to manage stressful events later in life. Also those children who have effective communication skills, can problem-solve and have the ability to reflect tend to be more resilient.

Resilience Factors in the Child:

- Secure early relationships
- Being female
- Higher intelligence
- Easy temperament when an infant
- Positive attitude, problem-solving approach
- Good communication skills
- Planner, belief in control
- Humour
- Religious faith
- Capacity to reflect

Resilience Factors in the Family

- At least one good parent–child relationship
- Affection
- Clear, firm and consistent discipline
- Support for education
- Supportive long-term relationship/absence of severe discord

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RESILIENCE FACTORS IN THE COMMUNITY

Support outside the family, e.g. close friendships or having access to a network of kin and neighbours, peers and elders for counsel and support, is an important factor in promoting resilience. Alongside this, schools that have a positive ethos, high morale and which support pupil's academic and non-academic achievement play an important role in promoting resilience.

Resilience Factors in the Community:

- Wider supportive network
- Good housing
- High standard of living
- High morale school with positive policies for behaviour, attitudes and anti-bullying
- Schools with strong academic and non-academic opportunities
- Range of positive sport/leisure activities

As disadvantage and the number of stressful life events increases, more protective factors are needed as a counter-balance. Individuals are often able to cope, so long as the balance among risks, stressful life events and protective factors is manageable. But when risk factors and stressful life events outweigh the protective factors, even the most resilient individual can develop problems.

What is important is that protective processes are put in place for all children and young people. These include:

- reducing the likelihood of negative chain reactions arising from the risk;
- promoting self-esteem and self-efficacy through the availability of secure and supportive personal relationships, or success in achieving tasks; and
- opening up new and positive opportunities and offering turning points, where a risk path may be rerouted[v].

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Handout for professionals

Here are some suggestions and ideas about what to look for during playful interactions and play between children, adoptive parents and foster carers.

What to look for when observing play and playful interactions

Containment

Does the foster carer or adoptive parent seem to understand the emotional aspects of what the child is doing? For example, he or she may comment on the likely feelings of the child or play characters.

Can the foster carer or adoptive parent acknowledge that the child has feelings about things that happen during play? For example, can he or she put into words that the child may be upset when a certain toy is broken, lost or unavailable, or a story is particularly scary or sad?

Can the foster carer or adoptive parent contain a child's disappointment or anger if play cannot proceed, or a child's anger or withdrawal if he is not winning?

Reciprocity

How well can the foster carer or adoptive parent follow the child's lead rather than making too many suggestions, instructions or interferences? For example, can they allow the child to experiment and be imaginative rather than structure the child's play with suggestions and commands?

How well does the foster carer or adoptive parent seem 'in tune' with the child's cues to initiate or end interactions or play?

Can the foster carer or adoptive parent allow children to try to work out difficulties for themselves but provide appropriate comments to acknowledge frustration? For example, *'You are really trying to put that piece in the jigsaw. You are annoyed that it doesn't seem to fit.'*

To what extent does the foster carer or adoptive parent attend to the child's explorations and experimentations rather than want to play with the toys him or herself? Children often like an adult to play with toys and activities with them, but may withdraw if this becomes competitive or controlling.

Does the foster carer or adoptive parent notice when a child needs a little assistance, suggestion or new idea to keep the play going? For example, an adult may notice the child's storyline has come to an end and so extend the theme to open new ideas: *'I wonder if that castle has anyone living inside it?'*

Does the foster carer or adoptive parent cope with feelings of dismissal or rejection if the child refuses to play with them or asks them to play somewhere else?

Behaviour management

How are boundaries decided upon during play? For example, is it the child, the foster carer or adoptive parent, or a joint decision that determines how long a play session lasts?

How are boundaries set within interactions and play? For example, does the foster carer or adoptive parent use warnings to let the child know playtime will soon be coming to an end?

What kinds of rules are asserted during the interaction or play? For example, will the foster carer or adoptive parent tolerate a child hurting someone else or breaking something without intervention? Is the child allowed to get so overexcited that he risks harming himself?

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