New-to-CAMHS Teaching Package

HeadsUpScotland
New-to-CAMHS Teaching Package

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Acknowledgements

Many people have helped and advised us during the completion of this New-to-CAMHS package. We particularly want to acknowledge Alison Burgess, Lynn Brown, and Gavin Cullen, who contributed to the writing.

We also acknowledge and thank all those who took the time to respond to the consultation.

Any weakness in the package is of course our responsibility.

AC/MG/DH/RW

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SECTION ONE: INTRODUCTION

This package is intended for staff who are new to NHS child and adolescent mental health services (CAMHS). It has been designed to promote self-directed learning with the aim of encouraging reflective thinking. In short, it is intended to help people who are new to CAMHS to grasp the practical value of theory to everyday clinical practice.

The ability to keep “a thinking space going” — especially when the day-to-day work with a young person is slow, sometimes unrewarding, or their problems severe — is essential for good treatment outcome, and for improving individual professional performance. Evidence-based practice [1] represents the ‘gold standard’ for NHS service delivery, but like many other NHS activities, much CAMHS work has a limited (if increasing) evidence base. So rather than uncritical acceptance of theory, a questioning approach, based on curiosity and the acceptance of uncertainty [2] is important.

People who are new to CAMHS have a variety of backgrounds and professional qualifications, and equally diverse initial roles, from nursing support of in-patients to representing CAMHS work in the community. This package has been designed for all; each can use the package to develop a personal framework on which to base their future capacity for reflective practice.

We have assumed little prior knowledge. However, since a number of good academic textbooks have been recently published [3, 4, 5] there is not much need for another. Instead, the text systematically covers specific topic areas that staff routinely encounter as significant challenges in their first year of employment. These challenges include:

- how to develop good inter-agency working — which must be an invariable aspect of CAMHS;
- how to communicate with young people — to allow problems to be more fully understood (including understood from the child’s point of view); and
- how to understand the complementary relationship between biological, psychological and social models, rather than seeing them as competing or incompatible [6].

Unlike conventional textbooks, there are no chapters about specific diagnostic problems. Chapters have instead been organised around practical problems that commonly confront CAMHS staff, drawing on detailed case-examples. For example:

- our review of deliberate self-harm (DSH), and its associated risk-assessment, is in Chapter 7 concerned with managing risk, where risk-taking is placed in context;
- depression has been reviewed in the chapter about managing risk, rather than as a discrete diagnosis, and is considered from a different perspective than in earlier chapters where the main models for understanding mental health problems are explored; and
- the management of an ADHD case is used to explore aspects of the holistic approach this package seeks to encourage, not to provide teaching on the diagnosis.
There is some conventional access to all the main issues related to CAMHS work — you can use the brief subject index and the appendices to find either the places where these issues are reviewed or directions for further reading.

**Aims and objectives**

We have assumed that people entering CAMHS work in Scotland will be relatively unfamiliar with the main ideas informing professional understanding of young people’s mental health problems, but that they are keen to work in the area and eager to learn more.

Working through this package should address needs in all the areas relevant to CAMHS work, including ‘useful’ theory, the key ideas that shape interventions to help young people, and how services across Scotland are organised to deliver these. The package should be a foundation for more specialised reading, e-learning, and other types of training.

The challenge (and the excitement) of working with young people arises from its complexity, influenced by how massive their developmental changes are in comparison with those of adults. These changes occur over relatively few years and extend from their biology, through their thinking, to their evolving social experience and roles. The ways they develop are determined by multiple factors, so a holistic approach is required if their experience and their difficulties are to be fully understood.

There can be short critical periods, where sudden gains or losses in development may be environmentally induced. Yet there can be remarkable recoveries of previously lost or inhibited function. This complexity offers considerable opportunity for intervention, and this underlies the optimism present in CAMHS work. Those interested in a good introduction to child development are strongly recommended to read the relevant chapters from Schaffer’s book cited in section 4.3.2 [7].

The main aim of the package is the development of reflective practice, where the ongoing practical value of ‘theory’ to day-to-day work is strongly evidenced. Although this can be challenging, by placing the individual child at the heart of the text, we hope the package will illuminate pathways of learning rather than leave new-to-CAMHS staff bewildered. Complexity must be respected, but need not be daunting.

**Overview of the teaching package**

The text aims to *introduce* rather than comprehensively *describe* all the conditions, theories, therapies, and service innovations for young people with mental health problems. Where excellent descriptions of these exist and can readily be accessed, these will be signposted (as recommended reading or in the bibliography). This editorial approach has assumed that individual CAMHS teams throughout Scotland have a small collection of books in each department, and good access to libraries, professional journals, and e-learning (e.g. NHS Scotland e-Library).

The system of signposting (see below), plus an extensive bibliography and recommended reading list at the end of many of the chapters, will allow new-to-CAMHS staff to pursue their own particular interests.
The subject index works like this:

- page numbers in bold refer to pages of the text where the topic is formally reviewed (e.g. 45-47);
- page numbers in ordinary type (e.g. 12, 28, 45, 111) refer to any page of the text where the topic appears;
- not all topics are formally reviewed; so a number in brackets indicates where a published text can be found in the bibliography (e.g. [16], [17]).

To promote self-directed learning, there are textboxes for questions and suggested learning activities throughout the package. This should help new-to-CAMHS staff digest the material and refine their own questions.

The bulk of the teaching package is divided into four sections:

**Section 1** launches the package, using a long case-example where, over the first 17 years of the life of Kenneth, seven possible CAMHS contacts are explored. The case is not unusual, but it has been unusually laid out to bring alive many of the issues central to CAMHS work. It has two further purposes:

1. to allow you to recognise what you already know and highlight areas of future learning need; and
2. to indirectly raise additional questions that will vary greatly according to your individual professional background and current clinical role.

These questions simply highlight issues, rather than requiring a formal answer.

**Section 2** has three chapters which explore the main challenges found in CAMHS work:

1. Collaborative working, where health gain is produced by CAMHS staff working in association with others, e.g. by ensuring good multi-disciplinary and inter-agency working.
2. Effective communication with young people and their families, without which they are disempowered. It is introduced by another individual case, that of Danielle — a relatively uncommunicative twelve year-old girl with mild-to-moderate learning difficulties, possible ADHD, and challenging behaviour.
3. Maintaining a holistic approach to CAMHS work; this is introduced by a clinical illustration of the struggle a CAMHS worker encounters as she attempts to cover the work of an absent colleague.

**Section 3** is a ‘knowledge and skills toolkit’. Each of the four chapters opens with a statement of learning outcomes and concludes with a list of recommended reading.

Each chapter explains how to:

1. understand the growth and development of children (as a dynamic interaction between individual and environmental factors, with a particular focus on their family context, and on resilience);
2. focus on the child’s view of their world (including engaging children in therapeutic work and understanding ways of communicating);
3. understand the different models used to explain child and adolescent mental health problems; and
4. manage risk (including DSH, clinical risk-taking, etc); a review of appropriate child protection policies and procedures is included.

Section 4 contains a bibliography, a brief subject index, and related appendices.

**How to use this package**

![Diagram](Image)

The package is not intended as a stand-alone text for a new staff member to work through in isolation — each new-to-CAMHS staff member will need to be paired with a more experienced member of staff who will act as a facilitator for their learning. In order to make the best use of the package, new-to-CAMHS staff and their facilitator will need to meet regularly. Both should have their own copy of the package. They will also need to have good access to library material.

As well as general learning outcomes, individually-defined learning objectives could be progressively introduced once the general learning outcomes have been met. A group of trainees may also choose to divide up some of the set questions between them, each taking a lead on different learning objectives, and perhaps reviewing each others’ work. Those working in very small teams, especially where they are remote, might consider establishing study-links with trainees working in similar situations elsewhere.

Throughout, guidance is provided on learning opportunities arising from the text:

- ![Icon](Image)
  Indicates activities for you to think and reflect on an aspect of your work or yourself.

- ![Icon](Image)
  Indicates an opportunity for you to discuss an aspect of your work with a colleague or colleagues.

- ![Icon](Image)
  Indicates where you write notes on an activity and/or your reflections.

- ![Icon](Image)
  Indicates a reading exercise.
Anyone using the text for CPD purposes is strongly encouraged to develop individual learning portfolios in association with it, for example, using a workbook to record your thinking and enquiry around the questions raised. Depending on your supervision/facilitating arrangements, the portfolio/workbook could constitute a formal record of professional enquiry and development.

The order of the package as a set of modules doesn’t imply a linear trajectory. Many of the modules overlap, and constant cross-referencing between them is likely. Indeed, with increasing familiarity, this is to be positively encouraged.

The case illustrations which come earliest are the most detailed. This is so that groups using the text have a common clinical experience from which each individual can draw up their own questions and learning pathways as they work through the package.

The package should be approached flexibly, with new staff prepared to dip in depending on their interest and previous knowledge, not necessarily feeling they have to fully master a topic before moving on — a difficult topic can be returned to later.
Kenneth: a case study

This case study has been developed to bring together knowledge, skills, and attitudes, since these must be combined at an operational level for clinical practice to be effective and well informed. Reactive working with children or young people is otherwise difficult to avoid.

The case itself is not an unusual one, but it has been unusually laid out to bring the issues alive. The story of Kenneth, a young man approaching his 17th birthday, was developed out of the experiences of a number of different CAMHS clients, but it could have constituted the life-story of any one of them. At each stage of his possible encounter with CAMH services, a staff member’s capacity to establish a ‘thinking space’ about Kenneth’s complex developmental needs would have been important.

The case study is introduced by his presentation in adolescence at an emergency hostel for the single young homeless, where hostel staff had become concerned about self-harming behaviour. It then steps backwards through time, finishing with his mother’s pregnancy with him. Don’t attempt to answer the questions in the case study until you have some experience of working with children and young people. Instead just read and familiarise yourself with Kenneth’s story.

Single young and homeless

Since arriving in the city from rural Scotland nine months before, Kenneth had lived at three different addresses. These included sleeping on the floor of an old friend, and a failed council tenancy – which followed the death of Fiona, his flatmate (who held the tenancy) from an accidental heroin overdose. She had first helped him find his feet – “we were joined at the hip ... I still speak to her, if there was a medal, she’d get it”. His unresolved bereavement was evident to the staff of the emergency hostel where, after two more nights sleeping rough Kenneth had once again sought shelter.

Over the weekend, staff became concerned about his low mood, observing fresh new cuts on his wrist on top of healed scars. Although he seemed resourceful in other respects, with staff and fellow residents quickly taking to him, NHS24 were consulted. After some wrangling between tertiary care services (he had reported that he was still in secondary education*), an out-of-hours CAMHS team (SHO and charge nurse) visited the hostel.

* Although Kenneth had been unable to sustain attendance at the college (which Fiona, nine months before, had encouraged him to attend to retake Standard Grades and get some Highers), he still maintained contact with the guidance department of a local high school where one of the college lecturer had negotiated a place for him to study a specialised subject. He had asked hostel staff to tell the school’s guidance staff of his new whereabouts.
The CAMHS team elicited a history of episodic low mood that pre-dated his friend’s death, but were uncertain what to recommend as Kenneth’s presentation suggested considerable resilience, and it had included significant drug misuse — previous contact with delinquent older males while in care “had started us off on hash. I found out about LSD myself; speed came after that, then it was eccys, then coke. My body got so used to them I had to take more each time and get vallies for the comedown. Basically every homeless person I’ve met, every single one, says it’s an escape from reality, it’s another world – in that world you’re not homeless, not on the streets, not sleeping rough … your confidence goes up.” Fiona had helped him moderate his drug use, but the team wondered whether a harm-reduction team rather than CAMHS might still be the more appropriate resource for him.

Kenneth had viewed his depression as understandable rather than abnormal, seeing his intermittent low mood as secondary to Fiona’s death, to his life on the streets, and a consequence too of “come downs” from drug-taking (i.e. when the drugs wear off). He understood the concern of adults about his wrist-cutting, referring to adverse comments some of the hostel residents had made — “they say I do it for attention but I don’t, the one who said that can’t talk, she OD’d twice last week” — but said that he himself was not concerned: “it helps me feel relaxed, less depressed, distracts me … helps me feel that I’m in control”. The SHO felt that they had established a good rapport and believed him. Hostel staff were advised that an episode of serious self-harm — i.e. a suicide attempt — was unlikely in the immediate future.

Q1: What are your thoughts about Kenneth’s current and likely future attitude to services?
Q2: What are hostel staff seeking from the visiting mental health team?
Q3: How would you go about assessing the significance of Kenneth’s low mood?
Q4: How would you go about assessing the significance of his self-harming?
Q5: What service boundaries/gaps were involved, and how could these be dealt with?
Q6: What should the CAMHS team do next?
Q7: Do you know what the arrangements are for a similar case in your area?
Q8: In what way is Kenneth’s self-harm also adaptive?
Q9: Could that apply to his deliberate self-harm (DSH) – that it’s simply an unpopular non-high risk coping strategy?
14/15 years of age, leaving foster care

Kenneth re-entered a local authority residential unit precipitously, in the wake of the acrimonious separation of his long-term foster parents. Each of them had wanted him to stay; he had felt side-taking was impossible, so for some months each foster parent remained in contact with him, and with his teachers at school, where at first he continued to do well. He felt he didn’t know his new social worker — even though the frequency of contact increased after the breakdown of his foster placement. He instead preferred to speak to his home-link worker at school, whose counselling he had valued throughout the last turbulent period in his foster family two years earlier. She had been undeterred by his record of inattentiveness and clowning in the classroom; he believed her early recognition of his abilities had been important in assisting the school to engage with him.

Despite the fact he was keen to preserve his school achievements after the residential unit, it became increasingly difficult to do so as few of the other older boys in the unit had any regular daily commitment out with the unit. Ignoring their ‘laddish’ behaviour was a struggle, as was resisting their invitations to join them in behaviour he knew staff were unaware of. This was not a burden he felt he could place on his home-link worker, whom he felt had already helped him more at school than he had expected or felt he deserved.

Observing his academic decline and intermittent truancy, but unable to re-engage him as she had done before, Kenneth’s home-link worker brought up her concerns with the local CAMHS team during one of their monthly consultation meetings. Two years before, she had discussed him with another member of the same team, who had suggested that if Kenneth didn’t settle down in his new school, it would be worthwhile screening him for ADHD. In the event, he had settled sufficiently for this possibility to have been forgotten.

Q1: School, foster-parents, and the home-link worker all provided him with important support, yet social decline still occurred. At the last consultation meeting people discussed how, despite inter-agency co-operation, a lot of good work with Kenneth was becoming lost. What are your thoughts about how that might have been prevented?

Q2: ADHD had been a possible focus of specific CAMHS involvement. How would a team have gone about assessing Kenneth’s ‘ADHD’ behaviour?

Q3: If ADHD problems had been present in 1st/2nd year at secondary school (S1/2), why had concern about them faded since?

Q4: The change of care provision plainly disrupted his education; how could this have been prevented?

Q5: What are the possible reasons which might make Kenneth become unable to confide in the home-link worker, someone he had trusted before?
Q6: By S3 at least three separate agencies were involved. What are the arrangements for similar cases in your area, and do your colleagues believe these work effectively?

12/13 years of age, first received into care

Kenneth had entered care after the death of his remaining grandparent. Emergency foster parents, who had supported him during two of his grandmother’s last hospitalisations, expressed their great regret at having no available place for him when she was dying. They recommended a younger foster family as he seemed rather immature, was easily drawn into impulsive behaviour, and they were aware that he had been under-achieving at school. It was agreed that he might do best in a family where there were older children he could look up to, or much younger ones with whom he wouldn’t compete. The ‘right’ long-term foster family came up sooner than expected, and Kenneth quickly seemed to feel at home with them. His foster parents quickly renewed a previous relationship they had with their local high school, and were relieved at the interest his new teachers took in him.

Q1: An unpromising situation seemed to turn out well; what are key elements that would ensure this?

Q2: Everyone seems to be looking to the future. Would there be benefits of looking at the past?

Q3: If yes, how might this be best undertaken? Think about ways in which the past might be examined.

Q4: Kenneth felt quickly at home with his new carers. What evidence can you see for him showing emotional resilience, or emotional denial?

Q5: Only two agencies were involved (education [without educational psychology] and social work). What would you consider the reasons to be for a CAMHS consultation?

Q6: If a CAMHS referral was made, what would its focus be, and how would this occur?

Q7: What are the developmental issues associated with his grandmother’s solo care of him?
Eight years old, living with his grandparents

A CAMHS consultation had been sought by Community Child Health staff, wondering if Kenneth had ADHD. A Connor’s scale, completed at the school doctor’s request by his teacher, was borderline for ADHD (rather fidgety, inattentive, and restless, easily distracted, and often failing to complete his work). His grandmother, who before her husband’s unexpected illness 18 months ago had considered herself less robust than her husband, also described him as a handful at home.

Kenneth seemed cheerful and much loved, and appeared aware of how to maintain his grandmother’s involvement long after she would have preferred to have read the newspaper or watch TV before following her husband to bed. He asked questions about his grandfather’s physical symptoms and would sometimes check on him during the night. Kenneth showed no outward concern or distress about his grandfather, but occasionally complained of vague physical symptoms. During the day he was keen that – if his grandfather were too tired to play with him – then his grandmother should: “Play with me! C’mon Gran, you haven’t played with me for ages!” Weekends were OK, but keeping Kenneth entertained during school holidays had become more difficult, so friends of theirs sometimes took him for a half-day. The friends were always full of praise for him when he returned home, and he was always keen to recount his adventure with them in minute detail – responding to any attempt to divert him by “Gran!! I haven’t told you what happened yet!”

His grandmother agreed with his teacher’s view of him as rather changeable in mood, acknowledging that he “might be a bitty anxious”, and expressing her belief that his need for reassurance might be greater than his peers’ because of his grandfather’s health problems and the absence of his mother since his infancy.

Uncertain whether ADHD could account for this presentation, the CAMHS team considered additional ways of obtaining more detailed information about him, including referring him for a play therapy assessment.

The play therapist found him likeable, eager to enter the room and chatty. He noticed if the toys in the room weren’t as he had left them and showed curiosity about whom else had used the room. He was easily drawn into playing with the toys, which he did imaginatively. His play therapist was always quickly assigned a role, which was sometimes unexpectedly changed. Themes of illness and disappearance predominated, with police, fire-crews and health-workers often involved. Except for father and uncle figures, the various people in his play rarely included family relationships, but on several occasions he called the play therapist “Gran” or “miss” (which she assumed was his teacher). During the early sessions his stories never reached a conclusion (where well-being was restored or people recovered) within the time allotted. But by the fifth session, the play therapist felt that Kenneth seemed calmer, albeit remaining somewhat impulsive. Except when he was particularly absorbed, he was easily distracted.
Q1: Apart from a play therapy assessment, what other general assessment strategies would have been useful?

Q2: In what way was play therapy the best way of eliciting his thoughts and feelings?

Q3: If it was considered important to get him to talk directly about his thoughts and feelings (rather than expressed through play), what would be the necessary steps and how would you begin the enquiry?

Q4: What are the diagnostic criteria for ADHD?

Q5: What other useful ways are there of obtaining more detailed information about his individual functioning?

Q6: What might have been the CAMHS team’s differential diagnoses?

Q7: What or how does a ‘formulation’ add to the diagnosis?

Q8: What developmental issues were associated with his grandparents’ care of him?

Three years old, at nursery school
Prompted by questions raised by a child psychotherapy trainee who was on an observational placement at the nursery, a staff member had suggested to Kenneth’s health visitor that a CAMHS consultation might be useful. Learning of Kenneth’s distractibility and restlessness, the trainee had suggested that ‘attachment problems’ may be present, heightened by his mother’s disappearance two years before.

There had already been a discussion with a CAMHS-community mental health worker when the possibility of ADHD had been raised. The worker had offered to facilitate a referral should the problems persist, but nursery staff and Kenneth’s grandmother thought that Kenneth was much too young for the diagnosis to be made. Good developmental gains had occurred since he permanently entered his grandparents’ care (including motor skills, toilet training, physical growth, rapid language acquisition, and increasingly co-operative play with other kids), so they had hoped that his problems would recede with time and maturity.
Q1: Observing his behaviour prompted two entirely different speculations, one based on a medical/biological model (i.e. ADHD), the other psychodynamic (i.e. attachment problems); what do you understand by each model?

Q2: Think of examples where a purely medical/biological or a purely psychodynamic model is used. How could these be integrated?

Q3: No referral occurred until he was eight years old; was that satisfactory? Could any other initiative have been useful over the five years in between?

Nine months old, leaving his mother’s care

The local authority’s social work department had become involved to support the legal guardianship of his grandparents — their daughter had chaotically depended on their care during Kenneth’s early life. The grandparents often observed him to be hungry, unwashed, and wearing dirty clothes; although they never found evidence to suggest that he was deliberately physically maltreated. They were worried about small bruises, which they assumed reflected their daughter’s lack of supervision and care of him — this seemed confirmed by evidence of intermittent untreated skin and hair infestations. They had become increasingly reluctant to return him to her care, being aware of her drug-taking and poor partner choice; sometimes she seemed to concur with this, at other times she accused them of “trying to steal my baby… that’s what you’ve tried to do my whole life”.

Q1: Any thoughts about the inter-generational issues apparent in this case, and how might these have been addressed had an opportunity been identified?

Q2: Because of his mother’s chaotic life, with several changes of address (including twice moving to England), Kenneth’s health visitors had been unable to carry out their normal developmental assessments. What are the developmental milestones of infancy, those under health visitor surveillance, and which indicators would be of particular relevance for a case like Kenneth’s?

Q3: In what way would the good care his grandparents then intended to provide him have been ‘good-enough’ to meet his needs? If not, what additional support might have been helpful?

Q4: Are you aware of how many grandparents are in a similar situation in your area and, if they are likely to have additional support needs, what these might be and whether, in your area, these needs are generally being met?
Q5: Kenneth's grandparents were optimistic about his future well-being, although anxious about what damage may have resulted from his early life experiences. How realistic was that worry, i.e. what problems may have occurred?

Peri-natal period

Although Kenneth's mother was in her late twenties when he was born, her pregnancy had been unplanned, being one of the consequences of her chaotic lifestyle, which had also resulted in poor attendance at the ante-natal clinic. She had failed to engage with the counsellors introduced to her, one of whom represented a drugs-misuse service, and did not turn up at medical outpatients for investigation of abnormal liver function tests. She was already well into labour when she presented to the maternity department, and Kenneth was born after two hours with an Apgar score of four at one minute and eight at five minutes. Although his Apgar score had more or less normalised by eight minutes, he spent two days in the special care baby unit, where his mother frequently visited him. His grandparents made their anxieties about their daughter known to nursing staff, who then alerted the hospital social work department. Although she agreed with nursing staff that she would meet a social worker, Kenneth's mother was quite truculent on the social worker's first visit to her bedside, and once she had left the hospital, she did not attend the follow-up appointment as agreed. She first left the city of Kenneth's birth one month later.

Q1: Many child protection issues are apparent; what are these, and how might each have been best addressed?

Q2: Kenneth's grandparents had been concerned about what damage may have been caused by intra-uterine exposure to drug taking. In what way was that realistic? Do other mental health issues need to be considered too, including his mother's own mental health during and out with the pregnancy?

Familiarise yourself with the literature on the children of parents with mental health problems (not just those directly associated with substance misuse).
Kenneth’s experiences and mental health needs illustrate many of the issues that will be explored further in the following chapters. For those particularly interested in youth homelessness four texts are suggested below.

A special issue of the *Journal of Adolescence* on the topic (2005, vol 28) e.g. Hyde J. From home to street: understanding young people’s transitions into homelessness. p171-183.


SECTION TWO: CHALLENGES IN CAMHS

Chapter 1: Inter-agency and multidisciplinary challenges

1.1 Introduction
The Scottish Needs Assessment Programme report (SNAP) (2003) [8] recommended that the mental health of Scotland’s children must be the responsibility of many public sector service providers, not just the NHS. This chapter begins with a look at published policy intents, and then examines some of the practical realities of multi-disciplinary and inter-agency working.

New Scottish Executive initiatives include:

- *The Mental Health of Children and Young People: A Framework for Promotion, Prevention, and Care* [9]: where joined-up working between services is envisaged to reflect the reality that many different groups and professions can make a difference to children’s mental health and well-being.
- *Getting the Right Workforce, Getting the Workforce Right* [10]: an advisory report, commissioned by the Executive, on how skills might be released to improve the capacity problem in CAMHS (increasing the capacity at the ‘primary mental health’ level is another of the recent proposals included for consultation).

The variety of service providers include:

1. In the statutory sector, both ‘universal’ (i.e. primary care, education, social services, community child health) and ‘specialist’ (e.g. CAMHS, educational psychology etc).
2. In the community many non-statutory agencies have developed highly-regarded projects (e.g. Barnardos, NCH etc).

The current plethora of service providers has created many new opportunities for young people, but the diversity of the range of potential help can also produce uncertainty or confusion about where and how a problem is best addressed. The development of Community Health and Social Care Partnerships for the general population, and the Integrated Assessment Initiative for young people, which is education-led, should help this, but it is too early to know how successful such policy initiatives will be.

Joined-up working is a widely-agreed principle, but important practical problems remain:

- Concerns about the confidentiality of shared information.
- Multi-disciplinary working in some CAMHS has been difficult to maintain for practical reasons, e.g. skills shortage, etc.
- Except for educational problems and child protection concerns, there are few integrated care pathways and still fewer assessment tools to determine down which path a particular problem should be directed.
For example, the SIGN guidelines (e.g. for the treatment of ASD [11]) and ADHD [12]), and the NICE guidelines (e.g. for the treatment of depression [13], are concerned with the evidence-base for post-diagnosis treatment choice, yet even for these specific conditions, the guidelines do not offer any model for integrated care pathways that can be mapped onto a local region.

Any integrated care pathway should be based on good epidemiological data. There are, of course, different kinds of evidence which should be given equal importance e.g. patients' and carers' experience of unmet need [6, 14]. Given the competing ideologies, priorities, and professional cultures involved, there are serious challenges to inter-agency working. The remainder of this chapter will explore how these challenges can be better understood, and possible ways to address them.

### 1.2 CAMHS team functioning

The challenge of joined-up working can be met if we begin to understand other professionals’ viewpoints more fully — how they view children’s world and their needs.

The next time you attend a meeting with other professionals, try to understand how each views the child you are discussing.

For example:

- Make a record of the words each professional uses to describe what is going on for the child.
- Are you able to identify what these professionals’ priorities are? What do you think accounts for the differences? In what way are they different and in what way are they the same?

Discuss your findings with your facilitator. Don’t worry if you can’t see any differences, sometimes (very rarely) they aren’t there! And sometimes they can be quite subtle and need unpicking — your facilitator should be able to help you do this.

**Q1:** What agendas seem to be present in the meeting you observed?

**Q2:** How do these correspond to the professional roles within the CAMHS team?
Q3: How could case discussion/decision-making have been improved?

To help you think further about how teams handle referrals, consider how your service would have dealt with one or two of the following referrals regarding Kenneth’s presenting problems as they occurred throughout his life.

- Age 16, following out-of-hours assessment by the CAMHS team, regarding low mood, deliberate self harm and substance misuse, had they then referred him for further assessment and treatment.
- After Kenneth (then 14 years old) had re-entered a local authority residential unit; observing his academic decline and intermittent truancy but unable to re-engage him as she had done before, Kenneth’s home-link worker might have insisted upon a CAMHS assessment rather than accepting the CAMHS recommendation (for an indirect consultation).
- When he was three years old, at nursery school, had the health visitor decided upon a CAMHS referral, due to the uncertainty of the alternative explanations being offered to her.
- When he was nine months old (after entering his grandparents’ care), had the allocated local authority social worker sought an opinion on behalf of his grandparents’ concerns, seeking reassurance that his intra-uterine exposure to drug-taking had not harmed him.
- Had the hospital social worker, prompted by concerns expressed by nursing staff at the time of his birth, and endorsed by his visiting grandparents, sought an opinion from the CAMHS team on possible Child Protection concerns.

Make notes in your portfolio about one or two of these potential referrals, and answer the following questions:

Q1: Who would deal with the referral and when would they do it?

Q2: Do you think the referral would have been accepted by your service - if yes - why? If not - why not?

Q3: How would the referral be allocated and who would be the most likely person to see Kenneth?

Q4: If you think the referral would not have been accepted, what would have happened to Kenneth?

Q5: What kinds of therapy/treatment would have been offered?
Once you have answered these questions, you should meet with your facilitator to discuss your answers and find out his/her opinion. To help you get a different viewpoint, also ask a member of another profession or someone from a different service to yours.

How differently did the colleagues you spoke to think about how each referral would have been dealt with?

Can some common themes be identified? Discuss your thoughts with your facilitator.

Like any other branch of NHS work, effective clinical team functioning requires:

- a clear understanding of purpose;
- common aims;
- clear communication and review procedures; and
- a leadership style to support all of these [15].

CAMHS work, in common with paediatrics and any NHS specialism dealing with chronic conditions or high levels of dependency, often requires quite a lot of multi-disciplinary input, so mutual respect for each profession’s individual contributions is very important.

How clinical teams make decisions on individual cases may greatly vary, but it is likely that, in addition to the use of guidelines as these become available, common factors to take consideration of include: urgency of case; past experience; skills/resource availability; and allocations based on trainees’ needs (thereby bypassing the waiting list). Although this has not been systematically examined in CAMHS, evidence from the decision-making literature elsewhere may prove useful [16].

1.3 Managing difference

Managing difference is an essential aspect of a well functioning team. One of the main ways difference can become apparent is the kind of evidence that people use to support their work [6].

A CAMHS team is typically diverse; it is likely to include psychiatrists, mental health nurses (sometimes in nurse therapist posts), and clinical psychologists. There are fewer local authority social workers embedded within teams than there were 20 years ago, but primary mental health workers, appointed from a variety of professions, are now common.
The argument for retaining a multi-disciplinary team structure is to ensure the presence of a diverse range of skills necessary to effectively respond to the wide range of mental health problems referred to the team. Occupational therapists (OTs) and speech and language therapists have therefore been increasingly employed in CAMHS teams, as have family therapists and child psychotherapists. Dieticians are often associated with in-patient units; sometimes pharmacists too, play, music and art therapists.

How team members’ roles are allocated may vary considerably, as much of the evidence-base of CAMHS work is thin. Precedence – “that’s just the way we’ve always done it” – rather than evidence-based principles may strongly influence how, at a local level, CAMHS work is undertaken. This can be a source of conflict.

Attend a multi-disciplinary meeting where recent outpatient referrals are discussed. Consider whether decisions made at the meeting are informed by research evidence, clinical audit or by particular preferences of team members. (It may be that you cannot see what is informing decision making – if so make a note of this.)

Make notes of your findings in your portfolio and discuss them with your facilitator the next time you meet. Try to think of ways to improve such practice: what kind of evidence would you use to support this change?

Observing a team working together on new referrals does not necessarily throw light on how it carries out its function ‘downstream’ of that, i.e. how cases are taken off the waiting list, by whom, how further working together may occur, etc.

Find out how these tasks are carried out in your local CAMHS team. What can you discover about how different disciplines collaborate on cases, i.e. what interdisciplinary work actually occurs, on what types of case, and how team members reflect upon ‘stuck’ cases?

Make some notes about your thoughts in your portfolio, and discuss these with your facilitator.
Irrespective of who undertakes which role, an interest in and acceptance of difference is important. Maintaining open communication and recognising similarities rather than competing also contributes to respectful working. In this way, a full, shared understanding of the problem can be reached. This has been described as encouraging the “thickening (of a) description” of a problem, rather than disagreeing about it [17].

1.4 Integrated working

1.4.1 Between health and non-health services

CAMHS teams have to work with many different agencies, both statutory and non-statutory. These agencies may be very different, depending on the region in which you work. For example, many Local Authorities and non-statutory agencies have been locally developed to address family support needs.

Largely for historical reasons, within some CAMHS, clinical psychology resources have been separately developed rather than fully integrated within a CAMHS multi-disciplinary team structure. This may extend to some of their community liaison. In addition, specialist CAMHS for particular patient groups may have developed (e.g. for looked-after children [18]), or those with moderate-to-severe learning disability [19]). These services are most obviously influenced by population-needs, especially the size of catchment-population.

A follow up to the SNAP report [20] identified that problems with communication and liaison with other agencies, resources, working together, and preventing problems/early intervention were all experienced, with some professional groups noting certain aspects more frequently e.g. communication issues were most often a concern for teachers, community paediatricians and social workers. More positively those who had access to CAMHS consultancy found this very helpful, with CAMHS workers seeing this as a strength in their service\(^1\) [21].

Consultation can be provided in a variety of ways: group or individual; fixed session or on demand; clinical-based or area office-based [22]. Consultation potentially benefits all by enabling development of an integrated tiered system, improving communication, being readily accessible, providing a greater understanding of the roles of CAMHS by Tier 1 professionals (see section 1.5.2) and fostering referral patterns which are more useful to professionals and families.

Make a list in your portfolio of all the agencies your CAMH Service works with, what they do, and your relationships with them, i.e. do they refer to you, do you refer to them, do they offer consultation, do you offer consultation? Alternatively, rather than making a list, you might want to draw a flow chart or a mind map using boxes for NHS services, circles for Local Authority resources, and triangles for non-statutory services.

\(^{1}\) Consultation is defined as ‘a shared exploration with other professionals of problems and possible solutions in which the consultant facilitates the problem solving process for another professional or group’.
Arrange a meeting with someone who refers children or young people to your service - ask them what they think about the process of referral. You might want to ask them about the clarity of the process, whether there are problems with the referral process, what would stop them from referring, do they have alternatives if they can’t refer?

Consider how your service meets (or does not meet) different cultural needs - does this affect decisions on referring to your service? You will probably be able to think up more questions!

Consider how, and in what ways your service meets the needs of LGBT (lesbian, gay, bisexual and transgender) people.

Make notes of your findings in your portfolio and discuss them with your facilitator the next time you meet.

It’s often useful to think about a particular type of problem, e.g. how the ‘journey of care’ for a school-refusing child might look, or for a teenager with behavioural and depression problems where mild learning difficulties are also present. Don’t forget indirect work, where CAMHS staff provide consultation to other agencies, as the case-example of Kenneth illustrated.
1.4.2 Integrated working within the NHS

With primary care

GPs are the most common source of referrals to CAMHS throughout Scotland, but there is considerable variation in the amount of information they provide at referral. The type of developmental information described in section 4.3 is rarely included, but some information about the family is usually given if known to the GP.

What do you think might be the best ways to improve the information available to CAMHS teams to review new referrals?

Make some notes in your portfolio about your thoughts. Discuss these with your colleagues. Do they agree, or tell you of practical problems that would prevent some good ideas being implemented?

With community and hospital child health

The association between CAMHS and NHS child health (both paediatrics and its community resources) varies greatly from region to region, largely for historical reasons.

Any future re-design of child health services should include child mental health. The main recommendations from the recent SNAP report [8] should be applied to any re-design, and account taken of the ONS national study which demonstrated an equally strong association between mental health and physical health problems as with social adversity [23].

What ideas do you have about helping to foster closer working relationships between CAMHS and NHS paediatric services?

Make some notes in your portfolio about your thoughts, and discuss these with your facilitator.
1.5 The national context

1.5.1 Scotland

Scotland’s *Children and Young People’s Framework* document [24] offers broad guidance on how services that address mental health problems might be organised. Following the *Kerr Report* [25] and *Delivering for Health* [26], the new Children and Young People’s Health Support Group at the Scottish Executive has published a consultation document on the Scottish Executive’s website (www.scotland.gov.uk) which offers an ‘action framework’ for child mental health problems, including specific outcome indicators for the reduction of suicide, and a stronger primary care role.

Look up this consultation document and think about its strengths and weaknesses, and how its most important ideas might apply to your local CAMH Service.

Make notes in your portfolio about your observations, and compare these with those of your colleagues. What issues do they see as most important, and what obstacles to implementation do they foresee?

1.5.2 England and Wales

CAMHS has become firmly located within the community division of the NHS throughout the UK. The HAS report [27] had structured services for children and young people’s health as a pyramid, with community-based services at the base (e.g. schools, social work, primary care). The structure set out below is still in use in England and Wales and remains widely spread in Scotland, even though it was not supported by the SNAP report because of its hierarchical appearance.

- **Tier I**: universal services, e.g. primary healthcare professionals, youth workers, teachers.
- **Tier II**: supporting Tier I by numerically fewer staff, each functioning relatively independently, e.g. community mental health workers, but often as a network and in the community. As often as not, they are jointly appointed by the local authority and NHS.
- **Tier III**: specialist services (almost invariably NHS), generally functioning in multi-disciplinary teams but also, on an individual basis, acting to support Tier II work.
- **Tier IV**: the end of the resource cascade, acting to support Tier III work (by providing intensive day and in-patient care). The function of these services is sometimes complicated by the necessity to bypass Tier III if urgent problems present, and by any wider (i.e. regional/national) area responsibilities of the service.

It is not uncommon for the remit of workers to straddle tiers. Significant gaps in local CAMHS provision are readily identified by this model.
How well does this apply to CAMHS provision in your area? Using this framework, can you see how these are linked, what gaps exist, what opportunities are taken, and whether any opportunities seem overlooked?

Make some notes in your portfolio about your thoughts, and discuss these with your facilitator. Do the issues raised seem to be mainly local, or are there some that are likely to be widely found?
Chapter 2: Communication challenges

2.1 Introduction

Good communication is essential for CAMHS work. First, between the different agencies often involved in a case; second, between young people and service providers. Kenneth’s situation at 16 illustrates the importance of both — witness the different views taken about his drug use and self-harming, and his own less alarmist attitudes and the matter-of-fact language he used to describe it.

Kenneth was 16; younger children’s voices in the NHS are less easily heard. Teachers in primary schools expect to learn of many of the children’s needs directly from them, unassisted by parents, but the same can’t be said of most NHS staff. The unarguable importance NHS service providers place on their relationship with parents can lead to overlooked opportunities to take the children’s opinions into account as fully as their parents’. If these are overlooked, the empowerment of children within CAMHS is likely to remain an intention rather than an achievement.

As any primary school teacher would argue, good listening and observational skills are as essential as interviewing skills, as is the ability to apply systematic thought to what has been heard or observed. But unlike teachers, CAMHS staff can’t rely on their longstanding familiarity with a child to make sense of their communication.

Theoretical understanding of the various ways children and young people communicate emotions, and how this is affected by age, stage of development, and socio-cultural factors, are all important. But they’re not enough — observation and practice are essential. Undue reliance on parental contributions can only be avoided if CAMHS staff have the skills for effective communication with children, e.g. being able to invite their further comment or response, to question when something isn’t clear, and to reflect back comments. This, in turn, helps the child become less muddled about what they are feeling and thinking.

The case of Danielle, which starts on the next page and involves many agencies and diagnostic labels, highlights the importance of this capacity to facilitate a far clearer understanding of a young person’s problem, rendering them no longer so bewilderingly complex.
Danielle

Brought to an out-patient clinic by her long-term foster parents, Danielle – a twelve year old girl with mild-to-moderate learning difficulties – was receiving long-term stimulant medication. Increasing behavioural difficulties had been evident in her new school, which had accepted her cautiously on a part-time basis. Even this schooling was now in jeopardy because of her restless, disorganised behaviour, and her foster placement too was under mounting strain.

ADHD alone could not account for Danielle’s recurrent conduct problems. During two recent consultations she had demonstrated an unexpectedly good memory for the rooms, toys, and names of staff from her attendance at the outpatient department several years before. Intermittently dispersed throughout these two consultations, which were otherwise characterised by restlessness and regressive play with dolls, she demonstrated a surprising attention to order: Danielle repeatedly sprang from her lying position on the floor (where she was playing with the toys she had found) to inspect the cleanliness of the room, finding dust on the leg-struts of chairs and lost papers under the desk, tidying things up, and giving a running commentary as she rushed about her self-appointed tasks, all of which seemed purposeful, produced results, and were difficult to interrupt.

The pattern was far more pronounced at the third consultation, where Danielle proved much more difficult to engage. She had been immediately and obviously disconcerted by the unplanned absence of one of the pair of staff she had met before, going to the window several times when she heard a car approach to enquire if this meant the absent staff member was arriving. She was too unsettled to remain playing for more than a few moments at a time, going through all the toys, crayons, and pencils to place them in long lines, the order determined by shape and size not by function, which she then repeated with the chairs in the room and with objects on the desk. Chaos alternating with rigid ordering characterised the consultation. Following it, the foster parent reported that Danielle had been excluded from school several days before because of violent outbursts (the trigger uncertain), and that because a withdrawal of her foster placement was also now possible, residential schooling was being urgently considered.

Danielle’s background

The eldest of several children to different fathers, Danielle has not been in her mother’s care since she was three, but in recent years she has had some regular if infrequent contact with her mother and her younger brothers, who are also long-term fostered. On these occasions their mother is observed to be reserved and emotionally detached. During the first three years of Danielle’s life, her mother had had a series of cohabiting relationships with abusive men. Many violent assaults on her mother (sometimes life-threatening or likely to cause severe injury) were observed by Danielle and her little brother. Neighbours were often concerned about their poor care, and both siblings had attended A&E for minor injury incurred whilst inadequately supervised.
Over her subsequent first four years in care, Danielle had seven family placements (including an adoption breakdown). Although erratic or aggressive behaviour was sometimes a problem, most of the placements ended because of events or stresses that were independent of Danielle. Plainly affected by all these difficult early life experiences, at the age of eight she had been offered play therapy. During her ten months of fortnightly sessions, she experienced two more placement-changes before going to live with her current long-term carers.

From the above, what do you think constitutes communication by Danielle?

Of the forms of communication you identified, make notes in your portfolio of those which might help you face her problems.

2.2 Responding to communication

Responding effectively to a child’s communication is useful for various reasons. A child with autistic spectrum disorder (ASD) can be helped to recognise social cues and meanings in conversation that would otherwise remain hidden from them [28]. With non-ASD children, psychodynamic work involves an on-going assessment, where reflecting back to the child some observation or thought that has occurred to the therapist helps to develop a fuller mutual understanding of the emotional predicament the child seems to be in.

Think about Danielle’s case study and make notes of how, if you had been present during any of her recent consultations, you would have responded to at least two attempts by Danielle to communicate.

Danielle had often played out family relationships during the play therapy, usually taking a parental position, for example, arranging the therapy room to look like her house and placing the therapist in the child position, to nurture her e.g. cooking for her or answering the ‘phone on behalf of the play therapist (e.g. “it’s your Mum. She’s lost but finding her way home. She doesn’t live with us; she can’t take care of you”). Whenever a reported difficulty at home had occurred, her play sometimes became frenzied; one of these incidents was followed by play with a doll’s house, where each room was carefully organised. Playing with animals often led to them fighting – as they “don’t trust each other”, with Danielle finally restoring the peace. In another game a teacher was really a witch and could fly (killed in one game, the teacher came back to life in another). In another session the therapist was placed in the role of a teacher, to tell her class the story of ‘Goldilocks and the Three Bears’. Following one of the placement changes, Danielle painted a house surrounded by fire and dark; a fire engine was present but she wasn’t sure that the family would get out. On another day, after she painted a similar engulfed house, she painted another house that was plain and had one of the doctors she had met inside, after which she enquired where the doctor was that day.
What thoughts do you have about how you might like to have responded had you been the play therapist four years earlier i.e. to anything you particularly noticed had been recorded in the play therapy notes?

Make notes about your thoughts in your portfolio, and discuss these with your facilitator at the next opportunity. If a psychotherapist or play therapist is available for additional consultation, share Danielle’s case with them and discuss your observations with them.

Finally, think about how you would convey your ideas about Danielle’s difficulties to a multi-agency meeting that had been convened to consider her needs? Make notes of how you would do this.

2.3 Professional cultures and language

A multi-agency meeting has been convened to identify additional resources that might help Danielle, or that could help prop up the failing situation described previously. Present at the meeting are:

- the allocated social worker and their senior (who will chair it);
- two school teachers (one managerial);
- an educational psychologist;
- staff from the fostering agency (one managerial, a project leader, and the support worker for the foster parents);
- the foster parents themselves; and
- CAMHS staff.

In her letter of apology, Danielle’s GP encloses copies of some early paediatric records she recently discovered in the primary care records.

Adults involved in the care of children use different language according to their discipline to describe what is going on with a child, as they use different perspectives to view their problems. It is helpful to unpack these different perspectives and how they are voiced. See Chapter 1.
Think how each of the professionals might talk about Danielle’s problems and what their main concerns might be:

- the allocated social worker
- his senior (who will chair the meeting)
- the two school teachers
- the educational psychologist
- staff from the fostering agency
- the foster parents
- CAMHS staff
- Danielle’s GP.

Note: to do this you might need to speak to other colleagues about the task, or take notes from your observations of their ways of communicating. Make notes in your portfolio and take these to your next meeting with your facilitator. Don’t worry if you find the task difficult (sharing your ideas with your facilitator may help you make sense of what you have written).

This is a complex case but if you have any thoughts about how the discussion would most helpfully proceed, and what might constitute a good outcome, note these in your portfolio for later discussion with others.

2.4 Hearing the same thing differently

Differences in perceived ideologies and practical realities that may become apparent during a case conference are generally not present in most families. Nevertheless, in most families major differences are likely to be present in what preoccupies each family member. For example, a recent intimidating encounter with a manager at work, or the continuing care of a partially disabled elderly relative may be on the mind of parents, whilst a teenager might be very concerned about their earlier falling out with a close school friend. All of these might affect listening, and what is heard.

In families with younger children, there will be considerable individual variation in the child’s capacity to understand communication, to decode non-verbal communication, to formulate thoughts, and to express thoughts and feelings [7]. In CAMHS work, further major influences on ‘what is heard’ by individual family members are common. These influences include ASD-impairment, or the rather less visible disability resulting from past trauma (psychological or brain injury), attachment loss, or the negative cognitions associated with depression.
Danielle is reminded by her foster parents of a forthcoming weekend with Joan and Bill, known to her as longstanding ‘respite carers’.

How might she hear this (thoughts, fantasies, feelings)? How is she likely to respond?

Make notes in your portfolio.

When Kenneth was eight years old, a CAMHS consultation had been sought because of concerns that he might have ADHD. He appeared cheerful and much loved at home, but his grandmother had described him as a handful, actively maintaining his grandmother’s involvement long after she would have preferred to retire to bed. If during the day his sick grandfather seemed too tired to play with him, he would turn to his grandmother exclaiming, “Play with me! C’mon Gran, you haven’t played with me for ages!”

How might Kenneth hear her reply “Not just now. I’m tired, I need to put my feet up”? And if Gran’ added “Go out and play in the garden for a few minutes, then you can come in and help me clear out the hall cupboard” or “and help me cook the tea”?

Make notes in your portfolio.

2.5 Deconstructing family communication

Neither Kenneth nor Danielle were living with their biological parents. Although such children, and those of single parents, are over-represented in CAMHS outpatients [29], children who still live with two parents (including step-parents) represent the commonest socio-demographic pattern in most clinics. Except for schools-based counselling and other types of drop-in service, the referral in most cases will usually have been instigated by a parent, rather than the child, so the parent will expect to attend the first consultation. This means that the voice of the child or young person, whether with the whole family or alone with their parents, is only one of several to be heard. The same issues apply whether seeing a child individually or with other relatives/carers: listening, observing, and responding.
**Stephen and his family**

This final case-illustration consists of a 45 second-long excerpt taken from the first few minutes of a family session as Stephen, a thirteen year-old ‘school refuser’ (who has been pointedly looking at his watch after hearing the meeting will last longer than an hour), breaks into the conversation to remind mother of his expectation that he will be going out somewhere later that evening (although he had not been at school all that week).

Mother: “No, you’re not going out tonight.”

Stephen: “But you said I could!”

Father: “She didn’t...”

Stephen (interrupting father): “She did! You did say I could!”

Mother: “I didn’t. I said that if you clean your bedroom, then maybe I’ll think about it.”

Elder sister: “That’s not the same thing Stephen!”

Stephen: “It is! You know she said I could.” (Turns to father.) “That’s not fair Dad!”

Father: “I think you should listen to the doctor.” (The therapist hadn’t been planning to talk at this moment.)

Sister (turning to the therapist): “He gets away with everything.”

Therapist: “Who?”

Father: “She [his wife] lets him off a lot. I’d be much firmer but nobody listens to me.”

Sister: “I do Dad!” (Father looks unenthusiastic about confirming this.)

Stephen: “Please Mum! I have to go. Tom’s expecting me.”

Mother: “No, you’ve not been to school today. So you’re not going out. That’s it!”

Father: “No. You’re not going.” (Interrupts Stephen’s protest) “Just watch it!” (Turns to the therapist.) “Sorry about that. You were asking...?”

Stephen: “It’s not fair!”

Communication between individuals in this family is not transparent. Not everything said gains a response, and statements and questions sometimes seemed to emerge from silent narratives.
Q1: What types of communication are present?
Q2: What do different family members want?
Q3: How aware of these agendas might family members be?
Q4: What might the therapist usefully do/say next?
Q5: What might be the greatest obstacles to being listened to?

Make notes in your portfolio.

Find opportunities to directly observe families, either noting communication styles in meetings you join, or from observing family therapy via a one-way screen.

Share your observations with the colleagues involved and with a family therapist if a consultation with one can be made available to you.

What differences might result if one of the family members, for example, Stephen’s mother, had a hearing impairment?

Discuss with colleagues what difference in family communication you would expect with, for example, a family where English is not the parents’ first language.

As Stephen’s scenario was drawn from the early minutes of an initial consultation, the therapist was largely listening rather than actively questioning. Approaches to therapeutic exploration of family communication, learning by expressing curiosity, are described in section 6.5.1 [30].

There is a brief review of the impact cultural issues can have on mutual understanding in Chapter 6. At this stage, it will be useful to consider the ways in which your own practice is culturally located.
Find opportunities to directly observe families of different cultural backgrounds, noting how the therapists engage with the family and any misunderstandings that arose which you think may have been culturally-determined. Compare your observations with colleagues involved in the work and make notes in your portfolio of any general issues that emerge.

2.6 Avoiding communication failures

Communication is a multi-level information exchange, and does not involve just words. This would certainly apply strongly to any meeting in which English is not the first language of all present — non-verbal behaviour, and indirectly provided communication, would then be even more important.

The multi-agency meeting convened for Danielle was likely to be challenging. Any discussion about how to deal with her “challenging behaviours” that did not rely on a full understanding of them was likely to fail. Taking account of all her needs was essential (i.e. emotional, psychosocial, medical, etc). The tasks involved in adopting such a holistic approach to CAMHS work are explored in Chapter 3.

The main principles involved in meeting new families presenting to CAMHS, and in establishing effective communication have been well described [31, 32, 33]. After three decades of different (sometimes competing) schools of family/systems therapy defining their own distinctive approaches, a consensus is emerging on how this is best undertaken. It includes how to:

- set the family at ease [33];
- ask questions [34];
- listen to their stories [35];
- explore and reflect on these; and
- facilitate changes that would improve individual and family well-being [36].

One current view in family therapy is that questioning is itself an intervention that can result in change.

Find opportunities to observe families directly, noting how the therapists engage with the family and the way information is elicited. Make notes in your portfolio and compare these with what you see being used by any colleagues doing group work with young people.

In discussion with your facilitator, find out about any observations they have made about your own communication style with young people, and how this may change in meetings when the whole family is present.
If the principles of effective communication were routinely present in Tier I and II work, one of the main aims of Scotland’s Integrated Assessment Initiative would be possible: to avoid families having to repeat their story unnecessarily [37]. That can only be possible if assessment has got to ‘the heart of the matter’. Even then, agreement must be reached on the resulting formulation and how to convey this to those whose support is deemed necessary to resolve the problems. For example, in CAMHS work, many mental health problems are formulated in terms of a bio-psycho-social model that may be unfamiliar to, or not used by, non-NHS colleagues, so the evidence to support this approach must be made very clear [38].

2.7 Failures in micro-communication

As Danielle’s case illustrates, failures in communication do not have to be large to have sizeable effects. Instead of her internal world difficulties being at the heart of inter-agency case discussion, talk about her challenging behaviours could dominate decision-making.

Without the professional language required to support Danielle and her placement, there is a risk that conversations would not encompass her experiences. These had involved at least four situations that would have placed her at high risk for emotional difficulty, every one of which Danielle must have some memory of.

- Deficits in her mother’s care of her (including their early relationship).
- The assaults on her mother that she repeatedly witnessed during her first three years.
- The repeated loss of carers (and how she understood each of the losses).
- Her mother’s reserved and emotionally detached manner whenever Danielle visits her.

Without responding to this knowledge, professional decision-making might be little more attuned to her needs than her mother was.

Thinking about these four past situations, make notes in your portfolio of possible ways you might gain some access to what memory she has of these.

The types of procedure necessary to meet Danielle’s communication needs i.e. to access her inner world experience, are explored in Section 5.5.
Chapter 3: The challenges involved in maintaining a holistic approach

3.1 Introduction
There are three main challenges in maintaining a holistic approach in CAMHS work: theoretical, practical, and deciding ‘who is the expert’ — the professional, the child or young person, their family, or both.

3.2 Theoretical challenge
It is important, when thinking about children and young people’s mental health problems, that a holistic approach is maintained. When thinking holistically, the body, the mind, and the environment in which a child develops are all seen as having an important influence. Critics of the biological approach to understanding mental health problems incorrectly assume it is based on mind-body dualism, and then argue that, not only is it simplistic, but could result in inappropriate labelling of young people’s unhappiness and impaired well-being as psychiatric disorders. Examples include disorganised or reactive attachment behaviour being diagnosed as ADHD [39], and excessive claims about undiagnosed ADHD being responsible for many childhood behaviour problems which may require drug treatment with Methylphenidate. Of equal concern to such critics, this approach would also deflect initiatives to improve the social adversities that contributed to these problems. Similar arguments might be applied to how depression was seen to be treated.

The recent public concerns about SSRI antidepressants for young people is an example of public anxiety about the unproven, even possibly damaging, use of prescribed medication [40], yet there is strong empirical evidence to support a biological approach to understanding some of the disposition to teenage depression [41]. For example a BMJ editorial, by a senior professional, internationally known for her work with psychological treatment approaches, recently argued that the successful treatment of depression calls for the application of an approach based on a chronic disease model [42].

Those upholding the importance of a biological approach are concerned that CAMHS’ current separation from the neurosciences and paediatric practice has allowed biological vulnerability to be more readily overlooked. This is particularly true for neuro-developmental disorders, e.g. individual vulnerability to Aspergers syndrome or ASD [43]. Much is now known about the importance of the brain in the development of mental health problems, e.g. functional neuro-imaging has demonstrated brain changes in ADHD [44], depression (especially longstanding depression [45]), past psychological trauma (e.g. PTSD [46] and sexual abuse in childhood [47]), and of the beneficial effects of psychotherapy [48]. The main problem in NHS practice is that the psychosocial needs of those with impaired mental health can seem to be frequently ill-met [49].
Good examples of how psychological approaches can work well with biological vulnerability are the different psychological approaches to reduce high expressed-emotion (EE) for lowering relapse rate in schizophrenia, and the use of dialectical-behaviour therapy (DBT) to help those with a biological predisposition to difficulties in regulating their mood [50].

### 3.3 Practical challenge

There are practical problems in applying holistic understanding. A holistic approach assumes the availability of a comprehensive set of interventions on par with those available for a physical health condition. That is frequently not possible.

The availability of skills within a CAMHS team to implement agreed national treatment guidelines is often very limited. For example, the NICE guidelines on the treatment of depression in young people (to which users made a considerable contribution) strongly advocate counselling and psychological treatment measures before any SSRIs are prescribed — according to the guidelines, whatever the severity of depression, medication should be delayed for at least 12 weeks. Yet, psychological treatments, for which there is a strong evidence base, are in short supply throughout the UK [51].

This gap in provision is coupled with the fact that not only is social adversity, which contributes considerably to depression, less well defined than physical factors, but resolving it is a complex and longer term task. As a result, at the primary care level, many GPs claim they experience a shortage of any timely interventions by CAMHS teams whereas, for those aged over 18 years, SSRIs can at least still be offered for palliative relief of depressive symptoms [52]. And from a public health perspective, the main problem about adolescent depression is its continued under-recognition [53] and its frequent under-treatment [54, 55].

### 3.4 Making space for the child or young person’s viewpoint

No individual profession’s viewpoint constitutes the sole truth about mental health problems, and neither does any offer a complete resolution for them. This argument extends to the relationship between any professional and their client about ‘who is the expert?’

Exploring children’s ‘narratives’ (i.e. their experience of difficulties) is increasing the NHS’s understanding of what constitutes effective healthcare; patients’ and carers’ own experiences and expertise are now increasingly integral to the design and delivery of healthcare, and should be encouraged. In fact, not only must the child or young person’s expertise be respected in clinical practice, but there is also growing recognition of the value of their experience in developing plans for health research e.g. sexual and mental health needs assessment of young people living in the ‘looked after system’ in Bradford (www.invo.org.uk).
3.5 Learning activities

The rest of this chapter comprises a set of learning activities associated with a single case-example, where the diagnosis (ADHD) is not in itself important. The three challenges will be explored using ADHD as an example, since despite the condition and its treatment by stimulant medication having a strong evidence base, both the diagnosis – as a concept – and its treatment by medication seem to remain controversial.

Among the factors contributing to the controversy are:

1. many of the associated behaviours overlap with other problems (even the core features of ADHD are common in the child population, e.g. inattentiveness, restlessness, and impulsiveness).
2. no objective measurement, e.g. a blood test, can discriminate ADHD from other problems that tired parents and concerned teachers may report, and who may seek a quick solution to their problem.
3. parental expectations and health-consumerism are factors which can put pressure on professionals to medicalise problems and heighten resistance to the exploration of psychosocial factors associated with ADHD.
4. stimulant medication is associated with side-effects.
5. one of the risks of the introduction of stimulant medication is that other needs of the child may be more readily over-looked.

Sean

Covering the case-load of a junior psychiatrist whose return from holiday has been delayed by an accidental injury, a new CAMHS worker fielded several telephone calls about an ADHD case. The first call was from the GP whom, on the basis of the Shared Care Protocol, had refused to sanction an increase in methylphenidate sought by Sean’s parents, without specialist advice. Two further calls on successive days were received from the child’s mother, requesting an early appointment. The case file of Sean, a nine year-old boy, detailed a number of telephone messages from parents over the previous three years, describing crises at school or in the home. A note from six months earlier recorded his parent’s request for a medication increase (which appeared not to have been granted); and several letters to the GP indicated an earlier psychiatrist’s concern that the parents were relying unduly on drug treatment. Several of the more recent consultations notes described parenting advice; two years before the parents had attended a ‘parents group’ for families with ADHD children, which they had reported on very favourably.

What do you think contributes to the controversial nature of ADHD, and why is methylphenidate a controlled drug? What should the CAMHS worker do next?

Make notes in your portfolio and discuss these with your facilitator.
ADHD is only one of several common explanations for poor school performance and troublesome behaviour, and in any one individual the presence of ADHD does not exclude any of the others. What are these other possibilities?

Ask your outpatient colleagues about their experience of ‘ADHD’ referrals, and what problems tend to emerge as the result of initial assessment. How frequently is ADHD confirmed, and what other difficulties are discovered? See if it is possible to make arrangements to sit in on an assessment. Make notes of your experience and discuss these with your facilitator. The issues that arise are likely to be of common concern to the outpatient team, and joining any team review of these would be useful.

Do you know what the central features of ADHD are, and which are most useful from a diagnostic point of view [56]?

The CAMHS worker arranged to see Sean and his mother. Sean followed her into the room with obvious unwillingness, responding to questions with “nothing”, “dunno”, or resigned shrugs. This, and his uncertainty about how long he had been taking the methylphenidate, its purpose, and the current dose, prompted his mother to take over the consultation: “you know fine well why I’ve brought you here”, citing increasing defiance at home and renewed difficulties at school. Aware that the CAMHS worker wasn’t observing the reported behaviour (Sean seemed inattentive and fidgety rather than hyperactive), his mother gave details of the difficulties at home, including not doing his homework, fighting with his sister, and delaying going to bed … “being hyper … he’s just hyper”. On direct enquiry, longstanding sibling rivalry was reported, and at least one of the “hyper” episodes seemed due to reluctance to give up boisterous play. The current daily dose of methylphenidate was 45 mg. The CAMHS worker was uncertain whether an increase was warranted, and was in any case unable to prescribe. The resulting prevarication was noticed by mother:

“He’s usually a lovely wee boy; it’s just that he’s grown a lot in the last six months. The teachers have noticed that too; he needs his dose increased. We were talking about that at the school meeting last week. This has happened before, a couple of times, and each time when it was increased everything settled down again. Isn’t that right Sean? Dr H was going to do it before the summer. I think she was expecting it to go up to 60mg”.

44
What should the CAMHS worker do next? Make notes of your thoughts in your portfolio. Have you observed such interactions in clinics? How did your colleagues respond?

Sean’s mother’s agreed to a direct contact with school, despite Sean’s protest. Pulling a face, he stared out of the window as the consultation concluded, got up out of his chair as his mother stood up, and reached the door before her.

The boy certainly didn’t feel central to the consultation process — authority and empowerment issues passed him by. In what way could this adversely affect the overall case-management, and how could such disempowerment be prevented?

Record your thoughts in your portfolio and discuss these with your facilitator. Empowerment is easily acknowledged, but in practice is complex, and the involvement of young people, especially children, may be seen as a difficult challenge by some.

The CAMHS worker was told by the head teacher that the meeting at the school had been called by his mother, not by school staff. They were aware he had been more unsettled on his return after the summer, but saw this as a “blip”, attributing it to renewed anxiety within the home (his father’s unexpected redundancy). They recalled that the methylphenidate had made “a real difference” when Sean had first been put on it in primary three; “we’re glad he’s on it, he’s a lovely wee lad… he was a bit of a loner but he’s got lots of friends now”. She didn’t, however, think any of her staff had noticed much difference whenever it had been further increased. She spoke of the learning support he was receiving “he’s really coming on, though he does find maths hard”.

ADHD without hyperactivity = ADD, where inattentiveness is instead the main problem [57]. It commonly co-exists with other problems. Do you know which problems it co-exists with, and what is meant in psychiatry by the term ‘co-morbidity’? Make notes in your portfolio.

The school didn’t confirm his mother’s report. This may represent ‘situation specificity’; this term is often used in child psychiatry – what is your understanding of it? Make notes in your portfolio.
In a child with ADHD the central problem is an inability, rather than a reluctance, to control their activity levels, attention and impulsivity. Where there is ADHD, symptoms may include: fidgetiness, restlessness (‘as if driven by a motor’), impulsiveness (e.g. blurring things out, inability to take turns, and, in some, reckless, even dangerous, behaviour), and attention-based problems (e.g. forgetting things, losing things, being distractible).

The CAMHS worker faced a difficult judgement: if no increase in stimulant medication was made, she was potentially under-treating his symptoms; but if she did arrange an increase, she may be compounding excessive medication use. Furthermore, the head teacher’s account and his mother’s account differ — how can she approach this decision without disregarding, and potentially alienating one of them? She also does not know what Sean himself thinks about which action should be taken.

What should the CAMHS worker do next? Make notes in your portfolio.

The CAMHS worker decided the best way to resolve her dilemma might be by reading through the case-file from scratch, to determine the relative weight the original clinician had given to the various factors influencing the original presentation, since these may not have changed much.

In other words, the CAMHS worker was wanting to go beyond the diagnosis (of ADHD), to understand how the case had been formulated [38]. What are the main features of a formulation, and what assessments would the CAMHS worker expect to see in the case file to have contributed information toward it?

Make notes in your portfolio, and discuss these with your facilitator. Find out how useful other outpatient colleagues consider ‘formulation’ as a concept. See Section 6.9 on formulation. Do they always mean the same thing when they talk about it? Does it invariably influence practice or are there exceptions? Discuss your observations with your facilitator.
Because of her health visitor background, the CAMHS worker was particularly interested in Sean’s early development, observing that the ADHD seemed only to have really become an issue after school-entry. Nursery school reports suggested that Sean had been slow to join in with peer-group play, with a tendency then to be distractible, dreamy and inattentive, restlessness only becoming marked after entry to primary one. The case-file noted a family history of ADHD (in male cousins), and that he had been a “precious” baby, a breech birth; his mother had PND (post-natal depression) after his birth [58], only later learning that he had been delivered with the cord around his neck.

The CAMHS worker decided to ‘phone the GP. Because the case-file contained none of the developmental records that, as a health visitor, she had been accustomed to undertaking, she used the opportunity of the ‘phone call to get these from the GP. The records sounded relatively unremarkable, which the GP pointed out was itself quite remarkable, as the original Apgar scores had been so low: one at three minutes, three at five minutes, and five at ten minutes. (Apgar is scored after birth: maximum score of 10 — up to two points each can be awarded for good skin colour, muscle tone, crying, active heart rate, etc.)

In what way would the emergence of information about the Apgar score alter the formulation, and thus influence the advice provided to the GP and to his mother?

Make notes in your portfolio.

In what ways might post-natal depression adversely affect child development?

Makes notes in your portfolio.

What do you think about when you hear/read that someone was “a precious baby”, or that “he’s always been a terror”? Makes notes in your portfolio.
The CAMHS worker joined her psychiatric colleague’s follow-up clinic on his return. She learnt that, prompted by Sean’s disquiet about further medication, his parents had talked with him about ADHD and the role of methylphenidate. They had showed him information they had printed from several web-sites [59-61]. Telling the psychiatrist that Sean was embarrassed about taking his midday medication, they asked about slow-release alternatives and about “the new drug that’s just come out; it’s supposed not to have any side-effects”. Sean himself seemed uninterested in the conversation, and when directly asked said that he didn’t want to take any more tablets. Looking surprised, his parents said that they “weren’t too surprised as he’s never liked taking them”. The CAMHS worker enquired what he could remember of their original introduction. Unable to remember anything of it but apparently feeling he had spotted an ally, Sean told her of a school friend who had been recently diagnosed, who had told him that he had been put in charge of his own treatment. To his parents’ surprise, Sean told them that his friend was monitoring his own behaviour, getting some individual help with it, that he was also responsible with his teacher for evaluating his day (“some days he doesn’t take a tablet but she knows he’s not to tell her!”), and that his friend won’t get any increase in medication without agreeing to it.

Are you familiar with the self-help literature and web-based information about ADHD? If not, talk with colleagues to discover the ways to find out; that’s what families have to do! Make notes of your enquiries in your portfolio. Discuss your notes with your facilitator.

Make notes in your portfolio of what you think might be the treatment principles Sean’s friend was describing to him? Could these still be applied to Sean’s treatment needs, or is it too late?

Discuss these with your facilitator.
4.1 Introduction
This chapter sets out to introduce the main concepts involved in understanding the growth and development of children. For some children much of this may take place out with family structures, but every child’s life begins with a relationship to their mother that starts before birth. Their subsequent growth and development may increasingly depend on others augmenting the care their mother provides, or even fully substituting for her care as in the case of Kenneth and Danielle. Subsequent development of these two children occurred in the context of complex and ultimately unstable relationship systems, which may have seemed unavoidable to the adults involved but were bewildering to the children. In fact, all children’s subjective experience of their environment is probably at least as important as any of the actual events they live through [62], and it begins before they can talk about it — the outcome of a dynamic relationship between themselves and their environment.

Over the last thirty years, three important developments have taken place in understanding the individual variation observed between children’s growth and development. The first two of these are reviewed in this chapter.

1. Appreciating the effects of social adversity and social exclusion [63].
2. More fully understanding the transactional nature of children’s experience, rather than viewing them as passive recipients of it.
3. Recognising that some children have greater innate difficulty in appreciating the emotions of others, and are less able to make sense of social interactions, e.g. where ASD is present.

4.2 Learning outcomes
This chapter should help you to:

1. understand growth and development as a dynamic interaction between the child and their environment;
2. become familiar with some of the key developmental stages of childhood, and how to get information about this;
3. when read along with Section 6.5, develop an understanding of key concepts drawn from systems theory, and how these may usefully apply to families you meet; and
4. reflect on the changes affecting families on an individual and societal basis.
4.3 Growth and development

4.3.1 Early life

In-utero growth and development is entirely dependent on placental feeding. A wide range of nutrients is essential, especially for growth during the last trimester of pregnancy and first six months of life. Foetal life is an active, rather than a passive, experience. For example, in-built reflex movements occur early (kicking, stretching, nesting), with susceptibility to sudden movement and noise, and responsiveness to the mother's emotional well-being [7]. These foetal life experiences are mediated by central limbic structures within the brain, which develop quite early. Affect is also located in these structures.

In-utero preparation for delivery involves pre-programmed behaviours of the baby. Similar pre-programmed behaviours are observable after birth, e.g. sucking and holding reflexes, and visual fixation and following behaviour. Although most of what happens before birth is subject to genetic control, intra-uterine experiences can also affect development, the best known of which are the effects of foetal exposure to alcohol [64] which, in common with many drugs and some infections, can cross the placental barrier.

This means that children’s earliest non-verbal experiences begin long before they gain any real ability to use language to communicate how they feel. Thinking and language require cortical development of the brain, which occurs quite late in brain development (see Table 1), but once developed it plays an increasingly important role in mediating experience.

Environmental influences become increasingly important after birth, sometimes with irreversible effects. For example, sensory deprivation in early infancy diminishes the growth of myelin sheaths and neural pathways (see Table 1). The earliest years of life are absolutely crucial for life-long mental well-being. Without early stimulation, stunting of neural pathways may occur, leading to irreversible stunting of affect and the child’s future capacity to form relationships. Inadequate stimulation can occur for many reasons — for example, developmental studies have shown how maternal postnatal depression can diminish reciprocity in the mother-infant relationship, flattening their ‘inter-subjectivity’ [65] (i.e. how attuned they are to one another). Brain imaging and neuropsychological studies have demonstrated a close relationship between brain structure and function, and the presence of ‘critical periods’ of development. This is the reason why, as a result of individual experience and developmental stage, children’s experience of an apparently similar world can prove to be so different.

The following table summarises how the brain develops and forms associations with early experience [66]. Rather less is understood about the brain correlates of later development, for example during adolescence when the typical ‘concrete’ thinking of childhood (when ideas are considered as absolute facts, etc) matures into a capacity to think more abstractly, to formulate hypotheses, to think ahead, and underpinning the social re-orientation of adolescence.
### Table 1: Brain development with early experience

<table>
<thead>
<tr>
<th>Time</th>
<th>Neurones and developing brain structure</th>
<th>Growth of connections between neurones (dendrites)</th>
<th>Myelination of dendrites (production of insulating sheaths to maximise their connectivity)</th>
<th>Associated normal developmental outcomes</th>
<th>Effect of deprivation and reduced stimulation</th>
</tr>
</thead>
</table>
| Conception to early infancy | Migration of cells (neurones) into new brain structures during foetal life. | Explosive growth from 28 weeks, maximum over next 7 weeks i.e. before birth. | Begins during foetal life. | 1. Reflex-type movements develop.  
2. Early affective experiences (limbic system). | Inhibits myelination, stunting or flattening affect. |
| First four years of life | Brain weight quadruples over first four years of life; much of this is cortex. | Continued growth of dendritic connections, until there is finally an excess compared with adult brains (in adolescence their number will become reduced). | Continues for four years after birth. | 1. Early interpersonal growth.  
2. Voluntary movements predominate over involuntary.  
3. Acquisition of symbolic understanding, and basis of all future language skills. | Inhibits myelination, with reduced learning potential. |
| Later childhood and teenage years until early adulthood | Cortical pruning begins: the most-used local neuronal networks are preserved [67]. | | | 1. Increasing ability to think in concepts  
2. Surges of gonadalsteroids at puberty induce further changes in the limbic system, rapidly expanding the emotional attributions being applied to social stimuli, especially novel ones, and other pre-frontal functions. | Under-development of neuronal networks involved in pre-frontal tasks results in reduced capacity for social judgement, impulse-control, and goal-directed behaviour. |
4.3.2 Developmental milestones

Child development occurs in a progressive way, with a broad similarity across cultures despite considerable variation between individuals [7]. No assessment of a child is complete without an understanding of how their developmental milestones were reached. These can be considered as falling within the following domains:

1. Birth to 13 months: acquiring posture and control of gross motor movements; hand function; early communication; person-social responding.
2. Fourteen months to five years: fine motor/perceptual co-ordination; language and other aspects of communication for social interaction; play and social interaction.
3. Five to 11 years: social maturation; educational attainment; self/other awareness and cognition.

In parents’ concern to discuss their anxieties about the here and now problems (e.g. tantrums and aggression), such historical events as developmental delay can be overlooked, only becoming known by direct enquiry. Without that, early delayed development, severe separation anxieties, poor awareness of others’ needs, or other evidence suggestive of neuro-developmental vulnerability, etc, can remain unknown.

There are three main sources of information, all of which may be useful:

- developmental records held by the health visitor (until school entry, thereafter copies are filed in the community child health records and in the GP’s primary care record);
- parents (where comparison with any siblings is generally useful); and
- teachers’ experience of the child (obtained by parental permission — primary school teachers’ knowledge of their pupils is usually very detailed).

It is never worthwhile rushing through this with parents. Even if no neuro-developmental vulnerability is suspected, systematic questions about their child’s development bring the child’s past experiences ‘alive’, and usually provide many indirect indications of the quality of family relationships. The recommended reading at the end of the chapter provides guidance on brief developmental paediatric texts that summarise the types of question which may be asked.

If possible, make arrangements to join a paediatric child development clinic. Note the kinds of questions asked and observe the child. Compare this to how developmental histories are taken in CAMHS. What differences do you notice and why do you think these might be present? Discuss your thoughts with your facilitator.

Make notes in your portfolio.
4.3.3 Infant mental health
Infant mental health is a relatively new, but developing, area of work within CAMHS teams. The first few months and years of life are a sensitive period when children develop attachments and learn about emotions and social interactions in their family. This lays the foundations, for both brain and behaviour, for future social, emotional and cognitive development [66]. Children who do not have secure relationships early in life are at greater risk of significant mental health problems, educational difficulties or conduct disorders. The recommendations set out in the SNAP report, and the Framework for Promotion, Prevention and Care, include a greater emphasis being placed upon consultation and teaching by CAMHS staff for community-based workers, e.g. health visitors, nursery nurses working in Sure Start programmes, and others concerned about infant mental health [8, 24]. Early intervention to improve the quality of the relationship between parents or caregivers and babies or young children may prevent damaging patterns being established within families.

What are the specialist services for children less than five years old in your area?

How does your CAMHS team provide consultation to professionals working with families who have children under five years?

If one of your colleagues devotes some time to this area of work, find out more about it, perhaps attend a consultation session and record it in your portfolio.

4.4 Resilience
This is perhaps the most important issue for studies of child growth and development: why children vary in their susceptibility to adversity, and what can be done to promote resilience (as well as to reduce the adverse effects on those affected by past adversity). We will only briefly describe it here, as very good reviews of the subject are available (see recommended reading below).

The adaptive flexibility of individuals and of families, and the support they receive for their efforts to manage – or recover from – their adversity, seems to be crucial in the development of resilience. Rutter, in his review of the implications of resilience-research for family therapy, highlights the importance of recognising individual vulnerability, abbreviating negative exposure, promoting good experiences, and supporting positive cognitive-appraisal of events [68]. These observations broadly correspond with other work derived from family therapy research and practice, e.g. belief systems that encourage “bouncing forward”, finding positive meaning, close family ties, open emotional communication, and collaborative problem-solving [69]. Such family strengths may be just as important for high-risk adolescents who are apparently disengaged from their family, as they are for younger children [70].
However, a parent’s mental ill-health may diminish their capacity to engage positively with their vulnerable teenager. There is, for example, a huge multi-disciplinary literature demonstrating the strong association between adolescent and parental depression [71], the causes of which are likely to be multi-determined.

Think of a family you are currently involved with. Are you as fully aware of their strengths as you are of their difficulties? Do you know how they managed all their earlier challenges? Discuss your thoughts with any colleague involved with the case.

4.5 The family

4.5.1. The changing family

The following factors have had a major influence on families over the last forty years:

- **Social changes**
  Children are increasingly born outside marriage and sibships have become smaller, or women have chosen not to have children. Single parenthood is now common, as is divorce and re-marriage with the formation of new sibships. Mothers are more often in work, and adults who are in work are less likely to remain where they grew up, so parent friendship groups or neighbourhood supports are tending to replace the supporting role of extended family [72].

- **Changing mortality and morbidity**
  Nineteenth century public health measures and 20th century manufacturing innovation have greatly reduced both mortality and morbidity, but have also resulted in the loss of parents’ ‘jobs-for-life’. The much-reduced manufacturing/production costs of food and entertainment has resulted in surfeit, so childhood obesity and ‘coach potato’ (or ‘Playstation’) lifestyles are relatively new concerns.

- **Social adversity**
  The ‘best’, or the most favourable, effects of these developments have least helped families who experience the most social adversity; the current average age of death of an adult male in east Glasgow is still only 59 years. Community studies have demonstrated that adversity tends to be persistent, rather than episodic, and involves multiple stressors rather than single ones. No doubt, for these reasons, the ONS epidemiological studies of child mental health problems [29, 73] have demonstrated very strong associations with social adversity, e.g. child mental health problems are at least doubled in households of more than five children, in reconstituted families or where there is a lone parent, where neither parent has educational qualifications, in low income families, where neither parent is working, in those living in council tenancies, and for social class V. However, as a recent review of Sure Start local programmes in the UK revealed [74], there is considerable cultural variation between disadvantaged or deprived communities, resulting in quite different implications for service delivery.
• **Information technology (IT) in the lives of children**
A new phenomenon, this has brought considerable independence of communication, with family involvement perhaps mostly confined to paying for it. Mobile phones (especially text messaging) and net-based communication now play a major role in the lives of most young people, so that even living in a remote croft may now be associated with little involvement between parents and their teenager, but greater interaction with peers than might otherwise have been possible. Young people’s IT access, including by the Web, can facilitate their access to much information and support they might otherwise have been quite unable to get. That can include easier communication with professionals involved in their care, which may be particularly useful in rural areas.

Think about the possible positive and negative impacts of these changes for families. How has society responded to difficulties and advantages that arise? Discuss your thoughts with your facilitator.

4.5.2 The family life cycle
In the same way that individuals can be thought of as progressing through a life cycle, so a developmental view can be taken of family life. The family system consists of three or even four generations connected on a variety of possible levels: emotional, biological, legal, geographical, etc. Unlike other systems, e.g. big businesses, there are few ways of entering or leaving the family; entry is by birth, fostering, adoption or marriage, and exit is by death (if even then). If members attempt to cut off contact with the family, they remain part of it on some level, e.g. emotional.

The family life cycle has been broken down in many ways into a variable number of stages, all of which have “tasks” associated with them which must be accomplished for the family to continue functioning successfully. The family system moves through time, with each generation adapting to transitions simultaneously. Times of transition are seen as periods of increased stress for families. Carter envisaged the flow of anxiety in a family in vertical and horizontal alignments [75]. Vertical flow consisted of patterns of relating and functioning transmitted through generations, e.g. family attitudes, taboos, expectations. Horizontal flow is the stress placed on the family by changes and transitions, both predictable (e.g. a child entering adolescence), and unpredictable (e.g. untimely death). The family is under most pressure when these flows meet, particularly if there are also environmental stressors (social, economic, political). These are the times that the family is most likely to develop problems.

Consider a family you are working with at present. Can you identify which horizontal and vertical stressors have been important in their presentation at this time? Which system levels are important? Discuss your ideas with your facilitator.
As we saw in the previous section, there have been many changes to family life and societal attitudes. This has led to criticism of this kind of model for failing to reflect these differences, e.g. divorce and remarriage, couples choosing not to marry, the changed role of women, LGBT relationships, the effects of social adversity and our modern multicultural society. All of these affect the roles adopted in the family and how families adjust to changes, e.g. Kenneth’s grandparents taking on a child-rearing role when his mother was unable to meet his needs. Nevertheless, these models represent the most accessible and helpful way to start to think about the family life cycle.

Describe a family you are currently working with. What has been their family life cycle? How has their family composition and circumstances compared with those of their parents’ families of origin? At a later stage in your training you may want to compare the family life cycle of several of the families you meet.

One of the most helpful ideas for families about a developmental approach is that of constant, inevitable change – that this difficulty, like others, will pass. It is important to recognise that a difficult transition is not the same as permanent trauma.

4.5.3 Non-shared family experience

It is now also widely accepted that even within a single family the children’s experience of their family can sometimes be very different, i.e. non-shared. The factors responsible for this may not be spontaneously recognized (or disclosed) by their family. For example, if one child had had significant exposure to alcohol as a foetus [64], or if the first two years of life of another had coincided with their mother’s prolonged postnatal depression [76], or for other reasons one had developed an insecure or disorganised attachment style [77]. Each of these is likely to result in significant non-shared later experience of their family i.e. experience that an unaffected sibling would not share.

Studies in this area have demonstrated that not only might it be likely that the family ‘niche’ of each would be rather different, but as time goes by such differences tend to increase, not reduce. For example, the second born of an MZ twin pair, observed to have a persistently lower neonatal Apgar score after a more difficult delivery, is likely in later childhood to follow an increasingly less favourable developmental trajectory. So despite growing up in the same family and sharing the same genes, their life-experiences will differ, and by adolescence their needs could be very different. Yet a later change in environmental conditions could disrupt the niche of both (e.g. impact upon all the family of the closure of the community employment-project that had supported the disabled twin).
Can you think of other ways the niche of one or both might become disrupted?

Make notes in your portfolio and discuss these with your mentor.

More subtle, or at least less ‘visible’, individual differences might be equally important in determining how an environment is experienced. Child development research, which began with studies on the effects on children of past gross social adversity [63] has extended to exploring factors that influence individual resilience [Chapter 19 in [4]] and to studies of siblings, i.e. why children from the same family can develop so differently [78].

Early differences in temperament have been considered important (e.g. in mood, adaptability, approach-avoidance, etc, [79]), especially where mothers respond to these in an unhelpful way.

Ainsworth’s early work on attachment had emphasised the two-way process involved. As later research on the effects of postnatal depression demonstrated that these can occur soon after birth [80], her ideas have enjoyed a renaissance, strongly influencing CAMHS work (especially for child psychotherapy’s concern with infant mental health).

Genetic factors, almost ‘invisible’, may also result in different experiences of the same family, and to different developmental outcomes as a consequence. For example, the drift of some young people into alcohol dependence [81].

Where there is an escalating retaliatory relationship between a challenging youngster and their parent, had the child started out the same as their twin or had they been different in some way, shaping their parent’s behaviour, or had they been more vulnerable to it – those at genetic risk for later psychopathy, for example [82]? Two-way interactions seem likely.

A longitudinal MZ (identical) twins research-design of kids discordant for behaviour problems had shown that high maternal expressed emotion (EE) over a two-year period was strongly associated with an increase in antisocial behaviour of the affected twin [83].

Children vulnerable to particular types of stress may have particular individual characteristics that alter their social experience, e.g. those with ‘theory of mind’ problems may have particular difficulty in responding to/avoiding punitive parenting, and thus be more prone than their siblings to develop behaviour problems [84].

Likewise in the development of teenage depression [41], i.e. where those without a particular genetically-conferred vulnerability are less affected by difficult social experience [85].
Such studies provide a compelling argument for different disciplines to work closely together, to share experience and respect differences in approach rather than ‘either/or arguments’ about nature and nurture, in order that future families can be helped as effectively as possible. Even addressing nature and nurture is not enough. Work with autistic spectrum disorders (ASD) has shown that to minimise the stress-symptoms of youngsters who have ASD, nature, nurture and niche are all important. The wrong niche (e.g. having an after-school job that involves dealing with impatient customers) can lead to much distress, sometimes to behavioural disorganisation.

Often the only way to establish whether such factors are present is to take a history that includes questions that specifically address non-shared family experience. With experience, these can be incorporated into family interviews alongside questions about family communication, emotional support, family crisis and how these were resolved, etc.

4.5.4 Meeting the family
Inviting the family to attend
A referral to your service is not, of course, where the story begins. Before the referral, the child, young person, a family member, ‘the family’ (or someone else) had identified a difficulty, probably tried to resolve it to no avail, concluded outside help was needed and gone to see the referrer.

The referrer will have formed an opinion about the problem and where to refer it to. Sometimes this is straightforward, sometimes not. The referral letter may or may not contain details of the referrer’s thinking.

When you write to a family, do you make sure the adults’ surnames are correct? (It is a common pitfall to assume the child’s surname is the same as that of the parent/co-parents). In what circumstances might such an assumption be especially problematic for the family?

Look at two referral letters of children or young people admitted to your service recently: what do they not tell you?

You are the allocated worker following an appropriate referral. The child is to be assessed and you have sent an appointment letter.

Q1: What kind of letter have you sent? Does your service have a pro-forma?
Q2: Do you offer a choice of time/date/venue or do you make that decision? If you offer a choice, someone (perhaps you?) may have phoned the family to agree on the appointment.
Q1: Does your team routinely include questionnaires (for example the ‘Strengths and Difficulties Questionnaire’ (SDQ)) with a request for the family to complete it before the first appointment?

Q2: The use of questionnaires has pros and cons. What might these be?

Q3: Try to put yourself ‘in the shoes’ of the family who has been invited to attend your clinic: do you send a leaflet about bus/train routes, car parking, how people reclaim fares, how long the appointment is likely to be, access to the building, etc? Try to imagine the kind of difficulties/questions people might have in seeking to keep the appointment. This is often an illuminating task. Addressing the practicalities in an initial letter can be a real first step in trying to establish for the family a sense of trust in the process (a process known to you but as yet unknown to those invited to attend).

Preparing the room
When the family arrives, what does the waiting room ‘say’ to them? Are you on time? This is good manners but it is also another facet in demonstrating a respectful process. Thinking about the structure of the day when you are scheduling sessions is often overlooked.

- The family’s day: there are times when any family with school age children is likely to find attending difficult, an obvious example being the start and end of the children’s school day.
- Your day: experienced clinicians learn over time to weave difference within their day and pace appointments to allow for reflection, sometimes recovery, and of course preparation time.

Is the room fit for purpose? Is it a glorified playroom, with ‘tatty’ toys – mostly stuffed animals and incomplete puzzles, plastic sometimes broken cars, dolls (invariably with no knickers!), toys that might interfere with talking rather than facilitate contact – ill-matching chairs, all of which are too low if someone has a bad back? Consider the age-range of the people the room will have to accommodate and the nature of what you will be doing. Check the room before you use it – a quick stock take: do you have what is needed e.g. markers if you intend to use a whiteboard?

Greeting people and introducing yourself
Let us now suppose that the family has arrived, you are ready and the room is OK. How do you greet people before taking them to the room? It is usually better to say “Hello, let’s introduce ourselves properly in a minute” rather than try to do more in the public arena of the waiting room.
It is not uncommon for people’s names to be called out. Can you think of the possible discomforts (or indeed risks) that this practice might engender?

Don’t be paralysed by all these potential pitfalls. We raise such questions to help you think through the difficult task of meeting the family, not necessarily because your clinic needs to change – most services do their best with systems refined over time, which will have benefited from being periodically reviewed.

Q1: When was the last time your service invited feedback about service users’ experiences regarding this stage of their referral?

Q2: What actions have/have not taken place in light of the feedback?

You are now in the room. How do you introduce yourself? You may only refer to yourself by your first name most of the time, but you need to give the family your title and your last name. In some families, it is not common for the children to refer to adults by their first name, therefore your practice would not be congruent. By giving both your names, and asking what ‘rules’ there are in this family, you demonstrate your wish to collaborate.

Think about titles. They can denote unexpected things to children:

- ‘Doctor’ may induce a child to think he is ill
- ‘Psych’ ‘ologist’/‘iatrist’/‘otherapist’: the ‘psych’ part may be worrying.
- ‘Clinical Nurse Specialist’: will a jab be given?
- ‘Social Worker’: will they get taken away, reported to the authorities?
- ‘OT’: what is that?

At this point it is often easy to overlook that younger children might want to play, others might be thinking about whether they will walk out if they don’t like what is to come. Are you or their parent/carer in charge of these matters? A brief statement to “please deal with the children as you would normally”, that you know playing and paying attention is possible, but you might need them to stop from time to time, can prove useful.

It is important to also refer to any equipment in the room, for instance a camera and one-way screen, and explain whether they are in use. The times when you forget to do this will be the occasions when someone notices the camera, and you spend time wondering about their anxiety.
The scene-setting is not yet completed. Whose purpose is this encounter going to fulfil: yours, theirs, others? How much detail do you refer to in acknowledging the referral? A helpful remark might be: “We understand you have a concern which you would like us to think about with you.” In time, you will settle on a stock of questions and remarks that work best for you. Sitting in on colleagues’ sessions provides good opportunities to gather some of these.

**During the session**

As your meeting progresses you will have to attend to both content and process. This will vary depending on the stages of therapy but also on what is going on during the session itself. You need to observe and note interactions between family members: who comes and who does not, who speaks for whom and how the story is told [86].

If you are making notes during the meeting you will have to acknowledge something about your note-taking. What should you say?

Lists in our head are helpful signposts about the range of dimensions we need to attend to: things like ‘child as symptom bearer’, ‘triangulation’, congruence between content and affect, family life cycle transitions. All of these will help you do an assessment but, especially for first meetings, establishing a collaborative encounter means enabling family members to offer their views and feel listened to.

What do the terms ‘child symptom bearer’, ‘triangulation’ and ‘distance regulator’ mean? If you don’t know, discuss this with colleagues and your facilitator.

When you take a history, either explicitly or not, you will need to include what has been done about the difficulty so far. What term will you use: difficulty / problem / worry / concern? Remember that terms are inevitably value laden and that someone in the room may feel that they are the ‘problem’.

Questions about whether different members of the family have different views can be illuminating. What other help has been sought, from family, friends, other professionals is also useful, as are feelings about the referral to CAMHS. Families often report the feeling that there is stigma in being referred. See Section 6.10.1.

What factors may be at play in relation to ‘stigma’ (see Section 6.10.1)?

You will need to strike a balance between enquiries regarding the nature of the difficulty and avoiding problem-saturated talk. Strengths and weaknesses and resilience should be noted.
How do you address issues of cultural diversity? Is it better to be clumsy than avoid this, and to be open about potential clumsiness?

When people clearly come from a different culture, it may be useful to ask what the family feels you might not sufficiently understand as a person of a different culture. But there are also hidden differences of culture. This is best acknowledged.

How can hidden differences in culture (social class, way of life, gender, etc.) be acknowledged? Discuss this with colleagues.

**Taking a family history**

Taking a history should not be sacrificed to process – developmental histories are vital to understanding a young person’s difficulty. The family’s history is also important within a systematic assessment. The use of a genogram, which is a sort of family tree (see [87] for further explanation of what a genogram is) can be profoundly helpful for this. After the assessment, it can be an explicitly therapeutic tool.

At the assessment stage, the use of the genogram must be well-timed: too soon can be presumptive (most, if not all families have some discomfort in their histories), and risks family members feeling the reason for coming is to be overlooked and judged.

Many practitioners avoid doing a genogram, believing it to be time consuming but it needn’t be [88]. They also fear to expose people to information that is either painful to themselves or untimely for others. Done at a timely stage, however, many families say they liked doing the genogram or report that it was helpful [89].

Genograms can combine biomedical and psychosocial information. They can underline a practitioner’s interest in the context of the referred person’s life; they invariably produce unexpected stories which may make connections between seemingly unconnected events and people. Genograms can reveal trans-generational patterns and locate a presenting difficulty in a historical context – therefore they can help in drawing together a formulation. If completed well, genograms allow for task (explicit information gathering) and process (how the task is done) to be available for analysis and synthesis.
The genogram below (Figure 1) is an example of one that could have been developed, using a flipchart, during an initial family session. It portrays the family of Donna, a 14 year-old teenage girl referred because of mild depression and eating problems. She presents as the rather gawky middle child of three, whose bereaved feelings about the death of her maternal grandmother, and the companionship she now feels she must provide her Grandad, are evidently not well regarded by her mother. Donna’s mother reported that she had never got on well with either of her parents, whom she felt had openly favoured her sister during her own childhood. Her relationship with that sister now, an aunt Donna likes, was “never the same” after her sister’s separation from her husband eight years ago; the two “aren’t speaking,” Donna’s father said. After his company went into receivership 12 months ago, he works south of the border during the week, but he came for the session. On his weekends home he seems supportive of his daughter, for example, sometimes accompanying Donna on her visits to grandfather’s house. He had encouraged her to go to the family GP to discuss her problems.

Using the family’s help to develop the genogram, the emerging diagram can usefully portray a summary of the emerging family history, for the family to think further about and to help identify possible themes of significance to explore. For example, with Donna’s family to enable further talk about intimacy, attachment, distance/separation/loss, and also about how conflict is dealt with.

**Figure 1: Genogram: the family of Donna**
Ending the session
Whatever checklist/pro-forma/tools you utilise – and for many it is a conversation – the session needs to finish on time. Concluding remarks must be determined by whether this has been a one-off meeting, one of a series of assessment sessions or a session within a series of contracted work. If it is the initial appointment for an ongoing assessment, you need to refer to other stakeholders in the child’s life such as nursery or school. You will need permission, both the child’s and the parent’s, to access them.

Consent for interagency work: do you explicitly note your request and the permission you have obtained in your notes? With the greater focus on this issue, you may need to send a letter counter-signed by the family to other agencies before they are able to share information with you.

Family members report that being given follow-up appointments at this point is more reassuring than waiting for one to arrive in the post. Not only can convenience be negotiated but many people have waited a considerable time for this first appointment.

In conclusion, thinking about the family in a clinical context and organising a first meeting with whoever attends, appears to be somewhat daunting due to the many different practical matters to attend to and the overarching task of providing those attending with sufficient psychological safety, containment and attachment. Managing anxiety – your own and others’ – can be partially addressed by the very practical step-by-step process indicated above. As to conducting the human encounter of such a meeting, you already bring experience and skills to the task that will stand you in good stead. It is helpful to think explicitly about what would worry you / the family the most – how do I respond if…? – and discuss this with colleagues.

If you are to make a home visit there are yet more variables to consider.

Find colleagues who routinely see people in their own homes. Discuss the pros and cons of different settings and what additional matters need to be considered if meeting people in their own homes.

Imagine you are the parent of a child referred to CAMHS. What five things would you need to be considered to have trust in the process in a first session?

Do your own genogram, and discuss it with a colleague you trust.
What assumptions, explicit and implicit, do you bring to thinking about families, children, young people and parents referred to CAMHS? Would any of these assumptions hinder how you seek to engage with service users? And if so how?

After the session
What action needs to be taken? There are notes and perhaps a letter to write. What is often not given sufficient time is an opportunity to reflect (see Section 6.10 for a model of reflection).

You are invited to reflect now on a recent encounter, with this section in mind. Would you do anything differently?

Each first encounter with different families will all have aspects which are the same for all first encounters and each, as with families themselves, will have aspects of unique difference. Establishing what is ‘routine’ for you to address will, it is hoped, free you to be open to the ranges of difference you will encounter, time after time.

Consider a family you are working with at present and discuss with a colleague the issues that have arisen in your work with the parents. Record in your portfolio how you have engaged them to think about the issues discussed.

4.6 Working with parents
Sometimes it is useful to see parents on their own. This subsystem of the family may need your help to:

- understand developmental stages better.
- understand their child’s point of view.
- think about and resolve issues from their own childhood (see Section 6.6.1).
- learn to work together in a more consistent and thoughtful way as parents.
- learn to work together as partners.
- clarify their fantasies, associations with and attributions to their child.
- understand the meaning of their child to them.

Many factors may affect parents looking after children – the illness or death of one partner, the illness or death of a child, miscarriage or still-birth. Parents who are separated or divorced may have particular difficulties in coming together as parents to consider and meet the needs of their children [90, 91]. Similarly, children growing up in step-families may struggle to find and place themselves in this new family structure [92]. Parents may also find it hard to negotiate a particular stage of their child or children’s development, such as adolescence. How they managed this stage in their own development may have an impact on their approach to this stage of the family life cycle (see Section 4.5.2).
Parents of children with special needs, such as children with autism or Asperger's syndrome, or children with chronic or even life-threatening illnesses may need time and attention to understand and work out how best to respond to the situation.

**Recommended reading**


For further reading, consult the following references in the bibliography: [93], [94], [95] and [96]
Chapter 5: The child’s view of the world

5.1 Introduction
In this chapter, we will be looking at ways of understanding children’s and young people’s views from different perspectives.

First, we will consider children and young people in the context of their families, taking into consideration the importance of early relationships, the impact of developmental stages on all members of the family, and the complex factors that might cause things to go wrong. For children or young people who are unable to live in their families of origin, we will consider how separation, loss or traumatic experiences might affect their development and pose difficulties for them in establishing new relationships.

Second, we will examine how these issues might be encountered in a clinical setting.

Third, we will consider the different ways in which children and young people communicate their thoughts and feelings.

Finally, you will be asked to consider your own experience as a child or young person and as a practitioner. The capacity to reflect on your own experience in the context of the work setting is central to learning from your experience. This chapter aims to facilitate your thinking about engaging with children and young people in therapeutic work.

5.2 Learning outcomes
This chapter should help you to:

1. appreciate the components of children’s and young people’s worlds in the context of their family, and the challenges it can face.
2. think about how to relate to and engage children and young people in therapeutic work, taking into consideration their age and stage of development.
3. consider various models for understanding children’s communications, and how adverse experiences can impact on a child’s or young person’s inner world and be expressed through behaviour, somatic symptoms or relationships.
4. reflect on your own feelings elicited in clinical work with children and young people, and consider whether these feelings might add to your understanding of the children or young people you are seeing.
5.3 Thinking about children and young people: in the context of their families

5.3.1 Thinking about children

Increasingly, research has borne out what families have always known – infants come into the world ‘hard-wired’ to relate – hungry not only for food, but also for emotional engagement. Being loved, held and cared for are central to an infant’s sense of well-being and to their development. In short, an infant’s physical, intellectual and emotional experiences are inextricably linked.

Recent studies in neuro-biology have confirmed the importance of early relationships — affect attunement, consistency, predictability and continuity — to an infant’s developing brain. (See Section 4.3.1.) John Bowlby’s early work highlighted the importance of separation from and loss of a primary care-giver to a young child. Over time, and in collaboration with others, he formulated a theory of attachment to describe the quality and patterns of attachment behaviour that can become established (see Section 6.6).

As Trowell and Bower (1995) summarise it: “A secure attachment forms the basis from which a child can explore the world and underpins the capacity for forming relationships with other trusted people” [97].

Young children depend on those caring for them not only to provide for their basic needs, but also to modulate and interpret the world and their experiences to help them make sense of what is happening and how they are feeling. It is through repeated interactions between the infant and his primary care-giver that a sense of self and the capacity to think is established. When mediated by someone who can receive and respond to the infant’s need for love and understanding, he will gradually begin to take in a feeling of being understood and to develop his own capacity to understand himself and others. See attachment in Chapter 6.

The theory of containment was developed by Wilford Bion to describe the emotional interactions between a baby and his mother or primary care-giver, but it also has relevance and applicability to therapeutic work. (See Section 6.6.1.)

Over time, a cognitive and affective ‘map’ of self and other is built up through an infant’s interactions and relationships. This model shapes the way a child anticipates, predicts and relates to the world, based on their experiences. That is, securely-attached children generally expect others, both adults and children, to be responsive, and relationships to be reciprocal, they generally have a view of themselves as worthy of positive regard and affection. But children who have been on the receiving end of adverse experiences — such as witnessing domestic violence, or physical, sexual or emotional abuse or deprivation — may be wary of others, and be unable to trust. Because assumptions about self and others are relatively stable and not easily changed, this can colour and distort the way a young child sees things and their relation to the external world.
The concept of an Inner World also encompasses the idea of unconscious fantasies and primitive anxieties, which can be experienced by children concretely (see Section 6.6.2). Often parents and workers attempt to reassure children who are distressed — to no avail — because not enough attention is given to understanding their perception of events, which may be very different from reality. Bad dreams and irrational fears beset even the most loved and nurtured child. Young children can quickly be gripped by fears of abandonment, starvation or retaliation, fears of witches, ghosts, or demons.

Young children also worry about their feelings of greed, possessiveness and potential destructiveness. Might their hatred in fantasy, and their anger as expressed in reality, damage or destroy the very person they love? Children struggle with intense feelings of love and hate, suffer guilt, and seek to make reparation. In good-enough circumstances, parents can help their children manage these feelings and not become overwhelmed. But young children can develop an overly critical or accusatory inner voice which can amplify and distort external admonishments, leading to excessive guilt or anxieties [98]. Young children test out their capacity to love and to be loved in their encounters with others. It is, however, their capacity to establish and maintain good relations with a loved person within their internal world that forms the basis of the beginnings of independence and maturity.

As children develop, they also need opportunities — to explore, to individuate, to learn, to form peer relations, to manage and to overcome fears and anxieties, to develop emotional strength and to have age appropriate experiences. Over time, with a developing sense of self, a sense of identity emerges — as a member of a family, as well as gender and ethnic identity. Language, ethnic and cultural issues are an important part of the experience of any child, and should be given due attention and thought [99].

Think about your own childhood. Try to remember what it had been like at three years, six years, 12 years — who you were close to and what was important to you? Can you remember ever being frightened? Who would you turn to in such a situation?

5.3.2 Thinking about adolescents

The difficulty for many young people centres on the changes involved in separating and individuating from their families and finding an identity of their own. As children develop from late childhood into early adolescence, the changes involved may affect the whole family. Parents can feel they have lost their child, who may have been delightful and engaging and is now uncommunicative or irritable. Siblings, too, can feel left out and left behind, as their older brother or sister spends more time out of the home or with friends. Family ‘rules’ have to be re-negotiated, while conflict often centres around the adolescent’s own struggle to accept more responsibility.
This is a new stage in the life cycle of any family, with each member finding themselves in a different position in relation to each other (see Section 4.4.2). There may be a conflict within the young person between rebelling and conforming, between seeking new experiences and clinging to what is familiar, between accepting the challenge of increased responsibility and being dependent. More often than not, an adolescent may oscillate between these positions or respond to the same situation differently, depending on their state of mind. ‘Going to the limit’ may be one way of discovering what the limits are and what they are capable of managing. For all concerned, it can be a scary time, with parents and staff worried about a young person’s safety or how their actions might impact on their future. At the same time, adolescence can also be a time of tremendous growth, achievement and creativity. A developing sense of self coincides with bodily changes and encompasses gender identity, sexual orientation and the potential for sexual relations.

Ethnic and cultural identity may be of particular importance to adolescents, in relation to both their families and their peer groups. Participation in peer groups can facilitate changes and provide a level of safety, a ‘psychosocial moratorium’ as Erickson described it, which allows for some delay before the intimacy and commitment characteristic of adulthood [100]. Being part of a group can “provide conjoint playground-cum-workshops concerned with identity where young people can find out, in conjunction with others, what it is like to be this changing, version of themselves: what interests them; whom they get on with, and why; how they experience their new sexuality” [101]. But some young people find themselves isolated, either not accepted by a peer group or unable to engage with others. It may be difficult for them to separate from their families, or they may be over-identified or enmeshed with their concerns. Others are reluctant to relinquish their childhoods, often withdrawing from the more active fray of adolescent activities. Still other adolescents become deeply troubled by the changes in their bodies that they cannot stop or control. For them, the onset of puberty isn’t a welcome and longed for change, marking the start of a new developmental phase, but a catastrophe which threatens to disrupt their sense of self [102, 103].

Not all peer groups are supportive. Some groups may operate more like a ‘gang’ in which members are either ‘in’ or ‘out’, and there is a subtle or overt expectation that everyone should think and do the same. Such groups can be a forum for anti-social behaviour. Adolescents in these groups can find themselves pitted against adult authority and rules, adhering to what Williams called “the false gods of drugs, drink and delinquency” [104]. Membership in a gang can engender a feeling of being grown-up, while simultaneously evading a sense of responsibility for oneself or others.

Think about your own adolescence. What did you enjoy about being an adolescent? What did you dislike? Were there any points of conflict? What opportunities did you have and how did you manage the transition towards independence?
5.3.3 Sibling relationships

Sibling relationships may well be the most long-standing relationships we have in life, longer than those with parents, partners or children [105-107]. Although when thinking about siblings, issues related to birth order or to sibling rivalry commonly come to mind, this does not adequately capture the wide range of individual differences in sibling interactions and relationships that have been identified in systematic research [108].

Several key findings will be summarised here:

- Relationships between siblings are evolving and take on different meanings at different developmental stages. Sibling pairs show marked changes in their relationship as they move from pre-school to middle school and into adolescence, where separation and individuation may be noticeably marked.
- Differential parental treatment has an impact on sibling relationships. Children are sensitive not only to how parents relate to them, but also how they relate to their siblings, similar to the way in which they monitor and respond to the relationship between parents.
- Sibling relationships have an impact on the developmental process through play. Independent of positive or negative affect, frequent co-operative and shared fantasy play is linked to understanding emotions and ‘other minds.’ One of the distinctive features of sibling relationships is that they can include both complementary (when they take on different, but dependent roles) and reciprocal features (when both partners take on matching roles). Sibling relationships can vary or be affected by the balance of these features.
- Children form an internal working model (see Section 6.6) of their sibling relationship in early childhood that is developmentally significant. Sibling relationships can form a ‘template’ for relationships with other children and developing friendships.

If you have siblings think about how your relationship has changed since early childhood. What strikes you about your relationship and has this been repeated in other relationships? If you don’t have a sibling, you might want to think about whether this has shaped or influenced other relationships in your life.
5.3.4 When things go wrong

In families

In families, problems can arise: suddenly, in response to an event or changing circumstances; in relation to negotiating a developmental stage, such as starting school or the transition to adolescence; or over a period of time. Often it can seem difficult for parents or carers to understand the problems as being part of relationship patterns or interactions. Problems identified in a child or their behaviour can highlight:

- more general problems in the family or between the parents.
- patterns of parent-child interaction that have become fixed or inflexible.
- parents’ perception of and interactions with a child that are coloured by their own experience as a child (see Section 6.6.1) [109].
- parent-child interactions that have become pervasive, persistent and characteristic in a way that is detrimental to a child’s development and may be emotionally abusive (see emotional abuse in Section 7.4) [110].

Young children are sensitive to parental projections and attributions. They are also sensitive to conflict between parents or carers, and find it hard to reconcile contradictory messages, inconsistent parental expectations or unpredictable parental responses. Young children find it difficult to hold a different point of view from their parents and to gain a perspective on things. Being told one thing and hearing or seeing another can set up a serious conflict within a child that can have on-going consequences, affecting their confidence in their ability to observe and to ‘know what they know’ [111]. Also, young children tend to see things from a self-centred point of view — people respond to them in a particular way because of their behaviour, or things happen to them or others because of their thoughts and wishes.

Lack of emotional availability, threats of abandonment, unexplained absences, or making a child’s continued care by the parent contingent on the child’s good behaviour or gratitude, all promote anxieties and insecure attachment.

Inappropriate imposition of responsibility, blame for mishaps and perceived failures, expectations for a child to accommodate to the parents’ needs, or inappropriate developmental expectations, all undermine a child’s developing confidence and increase a sense of failure and disappointment in themselves.

Children looked after and accommodated

Children and young people who are fostered or in residential care have already been separated from their families of origin, but may also have had traumatic experiences which precipitated their reception into care, such as physical or sexual abuse or neglect. The quality and nature of these experiences can vary significantly — for instance, whether an incident has been sudden and acute, or repetitive and persistent and characteristic of their relationships with parents. How a child understands such experiences and the way in which these may, in turn, impact on the child’s inner world is complicated and unique. What we do know is that the younger the child, the more all aspects of his development — physical, cognitive, emotional, behavioural and social — are intertwined and will be affected by adverse experiences. Nevertheless, some children will have remarkable resilience in the face of adversity, while others may be overwhelmed in a way that can seriously affect aspects of their development.
What follows are several key factors that should be considered when thinking about children who have experienced trauma, loss or neglect.

After reading each concept, try and relate them to a child or young person you have worked with, make notes in your portfolio and discuss them with your facilitator who may be able to give you further examples to consider.

**Trauma and loss**

Bowlby’s early studies of separation and bereavement highlighted the far-reaching impact of these events, particularly for children. In his three volumes *Attachment and Loss*, Bowlby outlined in detail the way separation and bereavement can be responded to and can affect children of different ages and stages of development [112-114]. Much has been written on trauma and post-traumatic stress in adults, but it was only more recently that evidence supported children as suffering from post-traumatic stress disorder (PTSD). Some children experience both trauma and loss at the same time — or may experience loss in a traumatic way. That is, they may be so overwhelmed by their experiences that they cannot grieve or resolve experiences of loss, which is an important step in moving onto form new relationships [115, 116].

**Cumulative trauma**

For some children, as with post-traumatic stress disorder, later experiences can act as a ‘trigger’, eliciting thoughts, feelings and responses that are related to a previous traumatic experience. For others, repeated or prolonged exposure to experiences of separation and loss can ‘re-injure’ the child from inside through the impact of their own thoughts and feelings [117]. Children who have been abused or neglected may also have missed out on the experience of being with a parent who could consider their feeling states, and help them to make sense of what they think or feel. The cumulative nature of these experiences may be difficult to disentangle and for children to understand or communicate to others.

**Loss and ‘developmental vacuum’**

For young children, all aspects of their development are linked to their relationships with their primary care-giver. The loss of a parent can leave a young child in a ‘developmental vacuum’, affecting their accomplishment of important developmental phases [118]. Although, as a child grows older he may come to understand the meaning of his loss, he may also be painfully aware that important events such as birthdays, or later, important transitions, such as leaving school or getting married, cannot be shared. Some older children and young people can feel that a further loss is that of their own childhoods, as they had been prematurely burdened by an experience, one that was not shared by their peers, leaving them feeling ‘on the outside’.

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Neglect and developmental deficit
Stevenson has written extensively about the issues and dilemmas related to children who have been severely neglected [119]. Most importantly, she describes the ‘cumulative deficit’ that can be experienced by children whose crucial needs are not being met in an on-going way. For instance, the loss of nurturing and stimulation at an early stage of development can impact on a child’s capacity to adjust and make use of a nursery school placement; the lack of early learning opportunities may leave a child disadvantaged on starting school, and so on. The unavailability of a warm and caring early relationship with a primary care-giver can leave a child wary or less capable of responding and reciprocating to others, even in a more caring environment, and can lead to further developmental problems.

5.4 Thinking about children and young people: in the context of clinical work
Seeing a child or an adolescent either as part of a family session or on their own can raise anxieties in even skilled workers.

- Will I be able to understand the child or adolescent’s feelings?
- Will I be able to put the family at ease?
- What will I do if the child becomes upset or will not settle or cannot separate from their parent?
- How will I deal with a child or an adolescent who doesn’t speak or is rude or abusive? And how will I manage all the feelings that may come up in the session?

In this section, we are going to focus on issues that might arise in the context of clinical work. In all clinical work, particular attention should be given to understanding and addressing language, ethnic, gender orientation and cultural factors for the families, children and young people you see. If this has not been part of your previous training, seek assistance from your line manager, colleagues or facilitator.

5.4.1 Thinking about referrals
Although the first point of contact for you is the referral to your service, the families concerned have already been on a journey. Serious problems of abuse or neglect or problems of delinquency may come to the attention of Child Protection Services, Social Services or the Police, who may initiate a referral. More often, problems have built up over many months, if not years, and parents will have worked hard to solve these problems themselves, or have sought guidance from family or friends. Parents may feel uncertain and anxious about seeking help and may have been reluctant to discuss these problems even with their GP. When a GP suggests a referral on to another service, i.e. CAMHS, the family may not know anything about the service or the type of help you might provide. Referrers, too, can vary in how familiar they are with the service and how thoroughly they have discussed the referral with the parents or young person.
Parents may agree with the referral, or be ambivalent about the referral, or in conflict with each other about whether this is the best course of action. Parents, children and young people may feel fearful of being blamed or guilty about having to seek help. With no clear picture of who they will see, even before a family comes to your service, they may have an image about what it might be like and perhaps mistaken beliefs about the clinic or anxious fantasies about how their problems will be approached.

Unlike adults, who may seek out help for themselves when in difficulty, children are referred to CAMHS by adults who are troubled by the child’s behaviour or presentation and concerned about their welfare. Although children are often aware that something is ‘wrong’ or that those caring for them are ‘unhappy’ with them, it is difficult — especially for younger children — to understand the nature of the difficulties others are concerned about. Occasionally, older adolescents may ask for help in their own right, but often they too are ‘referred’ at the instigation of their parents, and arrive at the clinic with their parents, irritable and upset, claiming that they hadn’t been asked to come, nor had they wanted to.

Think about a recent referral you have received. Record your thoughts about the child or family and any anxieties you might have about seeing them. Now, imagine what it might be like for the same family. Record what you think their thoughts and feelings about coming to your service for the first time might be. How do these two compare?

5.4.2 Preparing for a first session

On reading the referral letter or accompanying reports, you too might have a picture in your mind about the family and the nature of the problems they are grappling with. We can’t help having these thoughts — but might these preformed ideas colour your perceptions? You may have seen a very similar problem to the one referred, perhaps in a different work situation. You might need to devote some time to creating space to think about this family and to be open to their concerns, which might be very different from your previous experience.

Before a first session, you might consider whether you need further information, from the referrer, or from other agencies if they are also involved. For children who are looked after and accommodated, you may need to seek permission from the parent holding parental responsibility. You then need to think about whether you will be seeing the whole family, the parents only, or if you will be seeing the referred child with his parents or carer and social worker, or seeing the young person on his own initially. If you are seeing the family with another colleague, you might want to discuss how you will work together in the session.
When you receive your next referral make some notes in your portfolio about your preparations for a first session. Have you booked a room? What play materials have you made available – for the referred child and his or her siblings? And how have you arranged the setting and materials in the room?

How would you make sure the child or young person feels they are informed about what is happening?

5.4.3 Confidentiality and informed consent

These two ethical issues are central to any work with children and young people.

Confidentiality

It can take time for children and young people coming to a clinic to feel comfortable talking to someone they do not know. Establishing trust in this new situation is important, and their understanding that the sessions with you are confidential is essential to this process. Often, adolescents ask about this directly, but younger children may need you to explain what this means. Yet, if the sessions are confidential, how then do you share what you feel is important with those who are responsible for them?

Asking a child or young person if they would want any of the issues they have shared with you to be raised with parents or carers might be one way of addressing this. For older adolescents, time might be needed to help them raise important issues themselves, rather than speaking on their behalf.

While paying attention to the confidentiality of the child or young person, it is important that this is not done in a way that excludes the parents. It is important to establish a supportive and collaborative relationship with both parents and children.

But what if a child or young person tells you something that indicates they are at risk or being abused? Under Child Protection regulations and professional codes of practice, all staff are responsible for bringing these issues to the attention of the relevant people. (See Section 7.4 for child protection regulation.) In some cases, further time will be needed to understand the nature of the risk. But in all cases, young people need to be informed that if you are concerned about their safety or well being, you will have to let someone know. Young people should also be kept informed about how and when this information is shared.
**Informed consent**

This is an important consideration in all clinical work with children and young people. It is dealt with in Section 6.8.2 of this package.

With a colleague, discuss how you have addressed the issue of confidentiality with a child or young person. With your facilitator, consider a situation where the child or young person has raised concern that you were unsure how to share with others.

### 5.4.4 Introducing yourself to the child and family

Given what has been discussed in the previous sections, it is clear that a family’s experience of your service begins, before they come to the clinic, with the initial discussions with the referrer, the receipt of the letter or first correspondence from the clinic. How they are received at reception and the impressions they form in the waiting room all colour parents’ and children’s expectations. Most importantly, we need to think about how we introduce ourselves to families. Often, this is done so quickly that children are not given an opportunity to introduce themselves or to remember the names of the people who they will be seeing.

These early introductions and encounters can tell you much about the interactions between different members of the family. You should pay particular attention to who comes with the child, the child’s proximity to and relationship with their parent(s), and how they respond to this new situation. But what happens if some members of the family come and others do not? It is sometimes helpful to ask a child to tell you who is with them and who is at home, work or school, involving them in describing their family to you.

With your facilitator spend some time role-playing how you would introduce yourself to a family. How would you introduce yourself to a three year-old? A six year-old? A 12 year-old? A 15 year-old?

### Thinking about Kenneth

Now relate the sections you have just read to the case studies. Kenneth had been either known by or referred to CAMHS at different ages – at three years, eight years, 14/15 years and 17 years. At each point of his contact with the service, he was referred by a different professional and may have been seen by a different worker within the CAMHS service. In addition, his understanding of what was happening would have been different at different ages and stages of development — his experience of being seen in the service, from a child’s point of view, could be very fragmented and confusing.
In everyday life we are accustomed to reassuring children, particularly young children, when encountering new or unfamiliar situations — situations that we might anticipate a child being frightened or anxious about. But often children can feel relieved if their fears are acknowledged and realistically understood.

Kenneth, aged eight years, was described by his grandmother as ‘a bitty anxious’. Think about how you might talk to him about seeing you at the clinic.

Thinking about Danielle

It is often hard for new workers to imagine how much young children can remember or what might capture their imagination. In the case example of Danielle, she remembered the rooms, toys and names of staff from her attendance at the outpatient department several years before her recent referral, aged 12 years.

It may also be hard to imagine how much each of us as individuals might mean to a child or young person, especially if they have been able to invest in the encounter and establish trust in a member of staff. From a child’s point of view, every individual is unique. Children relate to people, not to roles — it matters who you are.

Think about Danielle at 12 years old coming to a familiar place, but seeing a different person, perhaps in a different room. With a colleague, role-play this encounter and how you might help Danielle orient to this new experience.

5.4.5 Engaging with children and young people

Including children in family sessions

In many clinics, families are initially invited to attend as a whole family. Considering the needs of the different family members and creating space for each of them to contribute to the session is often a tall order. Practitioners can find themselves bewildered by conflicting demands, with different family members competing for attention.

In exploring the problems presented, it is helpful to gain as full a picture as possible of the current situation for each family member. Have there been any major changes in the family circumstances? Have there been any illnesses or losses in the extended family? Most importantly, it can be helpful to explore how things were when the parents were the age their son or daughter is now.

At times, we may find ourselves empathising with one member of the family and not another, inadvertently mirroring the difficulties the family members may have in seeing things from their different points of view. Similarly, our own anxieties about what we should say or do can interfere with observing what is happening.
While gathering information about a family’s history or presenting problems, what’s happening with the children? Although only one child is usually referred to a service, when seeing the whole family, you should also pay attention to the way in which all the children may present difficulties differently — perhaps in ways that go unnoticed. Allow time for exploring their thoughts about why they have come with their parents to the clinic. Although it’s not always apparent, children listen carefully to what is being said and their play and drawings may have meaning in the context of the session. Good observational skills can help in enabling children’s communications to be ‘heard.’ (See Section 5.5.)

Before a first family session, decide with a colleague that you will primarily observe and interact with the children while your co-worker interviews the parents. Following the session, record your observations in detail and reflect with your colleague about the significance of your observations to thinking about the family as a whole. Record both your observations and your reflections on these in your portfolio.

In many CAMH services clinicians work in pairs for individual and family sessions. In the following case example, the meaning of the child’s play is unusually clear, whereas in many sequences of children’s play, the meaning of what is being drawn or played out is not always so accessible.

**Peter**

Peter, a five-year-old boy was referred by his GP for jealous attacks on his thirteen month-old brother. He had been brought up by his mother on her own for the last year since his father left the family after eleven years of marriage. Peter had not had any contact with him for that year.

Peter was seen together with his mother and brother by the clinic social worker and the specialist registrar. In the first session, Peter frequently asked the specialist registrar to play with him. While playing, he remained attentive to the conversation, sometimes interrupting his play to comment. When his mother was revealing the family background, he touched the registrar’s arm and showed him a scene he had just constructed with the plastic train. It depicted a bridge being crushed under the engine, detaching the engine from the rest of the train, three connected wagons. Interestingly, the last but one wagon contained the figure of a little child.
In the second session, six weeks later, Peter's mother reported that she had started divorce proceedings against her husband. While his mother was talking about this, Peter smashed the dolls' house, resulting in a mess on the floor with scattered toys and little dolls lying around. His mother reported that he had mentioned playing with the train when on his way to the session. This time, after asking the registrar to turn his chair so that he could see what he was doing, he let the train, now consisting of only two wagons behind the engine, run smoothly over the tracks. The registrar felt that Peter had been able to use his play to communicate problems he was having in relation to the break-up of the family (the first lost engine). His fear that his family was being smashed apart seemed to be illustrated by the scattered dolls' house and dolls. But he also conveyed a sense that his mother could get the family 'back on the tracks again' by being the engine pulling the two wagons (two children within the family) behind her.

In the second session, he turned to his mother saying that he loved her, and seemed to re-establish a caring relationship to her and to his brother. Following this, his mother reported that Peter was less distressed and treated his brother lovingly and caringly. His mother was happy with the situation and we left them with the option of contacting the service again if they needed further help.

(Michael Langenbach, Specialist Registrar, Nottingham, 1986)

Seeing children individually

Creating a space in which children can share their thoughts and feelings is often easier said than done. It is important to be sensitive and aware of the needs of children from a different ethnic or cultural background from your own. If a child's first language is not the same as yours, or a child has a specific disability, you may need to ask for additional assistance or guidance. Although preparing for a session is always important, children need time to explore and to make their own investigations about whether a person or a place is safe and reliable. At the same time, you will need to establish clear boundaries for your sessions to ensure a child’s safety.

Direct questioning can be difficult for young children, who can quickly feel under pressure to give the ‘right’ answer. They may also need you to explain things to them. Do they understand the words you are using? Is what you mean the same as what they think? Do they understand why you are asking them a particular question? You may need to check such things out many times in a session. Young children can also be reassured that you are listening and understand by feeding back what they are saying or doing. Even older children and adolescents can feel overwhelmed and confused if the discussion proceeds too quickly, so slow down, take your time, and introduce materials that may facilitate communication through drawing or play. (See Section 5.5.1.) Don’t assume you ‘know’ what they are thinking or feeling or ‘should’ think or feel. Children often surprise you in terms of their understanding, their empathy towards others, and their sense of responsibility.

It is often hard for young children to gain a perspective on situations. They tend to see things from a self-centred point of view — things happen because of their thoughts and wishes. Most professionals are familiar with the child who says that their mother is ill because of their behaviour. Such statements rightly lead to reassurances from the adults around them that this is not the case. But from a child’s point of view, these reassurances do not adequately address their fears or sense of conviction. Take time to understand their point of view and to ask them to tell you more about why they might think the way they do.
Record in detail a first session with a child you have seen individually. In your portfolio, reflect on the child’s explorations in getting to know you. How did you facilitate this process? What difficulties did you encounter?

Often, parents and professionals struggle with how much to tell children about what is happening or what has happened in the past, for fear of upsetting them or for fear that it will be too much for the child to understand. This can leave a child mystified or unable to ask. Often, children are aware of what is going on, although it has never been openly discussed with them. In situations such as this, you may need to spend time with the parent or parents to explore why it is difficult to discuss an important issue. What are they afraid of, and how do they think the child or young person will respond? Young children are very sensitive to the expectations of others around them and may have become aware that some subjects cannot be talked about. It may be hard for parents to acknowledge that their children are aware of issues they have tried to protect them from knowing about. This is a complex area of work, and professionals too can be drawn into colluding with a family’s wish not to explore difficult or painful issues. That is, professionals too can find themselves in the child’s position of knowing something, but being unable to ask, explore or think about it with someone else.

In your work with a family, have you ever encountered such a dilemma? Were you able to gain the family’s co-operation? Discuss with your facilitator how you tackled this, with the parents and with the child or adolescent. Make a note in your portfolio about the nature of the dilemma and the difficulties you encountered.

Engaging with adolescents

The adolescents referred to CAMHS span a wide age range — from 12 to 18 years. Similarly, the nature of the problems adolescents present can vary enormously. It is often difficult to know how best to begin — whether to see the young person with their family or carers, or to give them time on their own. As described in Section 5.4.4, it is important for the young person to know why they have been referred, who they are coming to see, and the purpose of the meeting. For some adolescents, the concerns of their parents or others do not match with their own concerns. From the adolescent’s point of view, the only problem is that everyone else seems to be worried about them! Can you engage the young person in thinking about these concerns without leaving them feeling they are the problem?

In engaging adolescents, it is important not to assume all adolescents are heterosexual unless they tell you otherwise. Ask them to tell you about themselves and be open to their sense of confusion, uncertainty and conviction about their sexual identity.

Issues of trust and confidentiality are particularly important (see Section 5.4.3). Discussing and negotiating what takes place in an individual session and what can, or must, be shared with others is crucial to establishing a therapeutic relationship. But what do you do if a young person is reluctant to speak or simply does not come? How might we understand and address this?
Troubled adolescents often are the least able to articulate the nature of their problems. They feel anxious, hurt or angry, but often find it hard to express themselves. Trying to understand a troubled state of mind might also be a challenge to your sense of self and reality. Supportive comments to someone who is depressed or deeply unhappy may fail to capture what they are trying to communicate — how bad they feel. Self-harm, such as cutting or placing themselves in dangerous or vulnerable positions, is often hard to understand. Why would a young person want to damage, hurt or kill themselves? Young people whose own families have been unable to support them through the turbulence of adolescence may be particularly vulnerable to acting out their distress in the absence of more secure relationships.

It is often hard for adolescents to sustain on-going work, either family work or individual work, as this can put them in touch with painful feelings and dilemmas. Not turning up, walking out, and complaining that what is being offered is useless, are all part of most professionals’ experience in working with adolescents. How can a service provide a flexible enough approach to take into consideration the fluctuating states of mind of a troubled adolescent? Regularity of session, continuity of workers, and attempts to maintain regular contact with the young person may all help in establishing a working relationship with them, but this is not always possible [104, 120, 121].

Consider how you might work with a young person who is difficult to engage or is not attending.

Discuss with your facilitator how you have approached this issue, either with the adolescent or by involving other people or services. Make notes in your portfolio about the various ways you have tried to address this problem.

A method for assessing sibling relationships
Parents’ descriptions of their children’s relationships with each other may not match the children’s own feelings about their brothers or sisters. To gain a more accurate perception of the children’s perspectives, we need to think about undertaking a sibling assessment. One model for this is to see the siblings together, perhaps on two occasions, and to see each sibling individually twice, seeing the oldest child first, the younger child second, and so on. Each child could be provided with a small folder or box file with some similar and some different toys and materials, taking into consideration their age and stage of development. When seen together each child’s box should be available; when seen individually, only the one child’s box should be placed out. The purpose of the pattern of sessions and the provision of materials is to offer predictability and consistency and to create a sufficiently stable space in which differences in presentation, conflicts and co-operation can be observed and thought about. Sustained attention to the detail of the children’s play and their interactions with each other, their verbal and non-verbal communication, symbolic and shared fantasy play should provide a clearer understanding of each child and of their meaning for each other [122].
Danielle was the oldest child, with younger brothers. Considering the material described by the play therapist in Danielle’s case study, are there any indications about what her relationship with her siblings may have been like? Think about and record how you might talk about this subject with Danielle.

Now consider a case you are involved with at the moment where there are concerns about the sibling relationship. Have you observed the siblings together in a family session? If so, record your observations and the parents’ interactions with each of the siblings.

Consultation
Consultation to other professional groups is an integral part of work in CAMHS teams (see Sections 1.4 and 1.5). Generally there are two types of consultation you might be involved with. The first is consultation in relation to a child or young person to facilitate thinking about problems presented and possible ways of addressing these. These consultations may take place in a wide range of settings or professional groups, such as to teachers, health visitors, social workers and others. Thought should be given to who has asked for a consultation, what their expectations are and the aim of the consultation meeting. Primarily such consultations are aimed at helping that professional group understand a child or young person and find ways of working with them – for example in school. At other times there may be questions about potential mental health problems and whether a referral to your service is indicated.

The second type of consultation that may be requested is to a specific group of workers, such as residential child care workers. Here a group may want help in thinking about how they are working together as a group and in reflecting on their experiences in relation to the children in their care. This is a more specialised task. However, in both types of consultation clarification is needed about the respective roles and responsibilities of the consultant and the participants. An important thing to remember in organisational consultation is that the task is a shared one and that understanding should grow out of the discussion, rather than providing an ‘expert opinion’. You are there to facilitate in their understanding in relation to their work context. In relation to group consultation, you might want to draw on concepts from systemic and family work, or from psychodynamic thinking (see Sections 6.5 and 6.6). In Chapter 7, there are several clinical examples and exercises that expand this area of work.

In some professional networks the dynamics of the family can be re-enacted within the professional network. For instance different professions may take different views in relation to the parents or children. Adult mental health workers may align themselves with the needs of the parents whereas child and adolescent mental health workers may align themselves with the needs of the children. In other cases conflicts between professional groups may arise in difficult-to-understand-ways. If this occurs you should discuss these dynamics with your facilitator who may help you to think about these in a different way [123-127].
5.5 Children’s communication

5.5.1 Play as communication
Alvarez and Phillips [128] emphasise “the importance of play as the transitional space between thinking and reality, in which ideas and the emotions which go with them can be tried out, felt, and made sense of”. That is, “Play does not reflect reality, but is how the child reflects upon reality” [129].

Children learn and develop through play. In the first instance, the beginnings of a capacity to play take place with a mother, or others, who can facilitate and reflect back what the child is doing. Gradually, what Winnicott [130] calls the “overlap of two play areas” develops, with the child and mother or others becoming engaged in more reciprocal play, turn-taking and responding. Excitement and enjoyment are characteristic of this type of play, which is integral to developing relationships. Over time, young children begin to invest other objects and toys with meaning and feeling, and can play on their own in the absence of their primary carer for varying lengths of time. The growth of symbolic play is an important developmental stage and enables a young child to begin, not just to master tasks, but also to come to terms with emotional experience. In this way, play can be thought of as a form of communication about states of mind, similar to dreaming in adults [131].

In clinical work, think about providing those toys or materials which will facilitate play as communication. But often, at the beginning of a session, young children may play hide and seek or a form of the peek-a-boo game. Might this be a way of noting going away and coming back, seeing and not seeing you and the clinic room between sessions? Play may be simple, or elaborate with a child taking on and allocating roles. Games can be confusing and disjointed, or play can be inhibited or absent. The quality of a child’s play and drawings can also highlight developmental delay or difficulties. The question is what do we make of our observations of children’s play? How can we understand and reflect on our observations? Is play ‘just play’ or should children’s play, either in family or individual sessions, be given closer attention?

In Kenneth’s story, the play therapist noted that themes of illness and disappearance predominated his play. What are your thoughts about what this play meant?

In Danielle’s story, descriptions were given both of the content of her play and the manner in which she played, for example, her restlessness. What meaning might be given to her play?

Now think about a sequence of play in a session with a child you have seen. Record your observations and your thoughts on your understanding of the child.
5.5.2 Behaviour and somatic expression

Play requires a certain level of concentration and engagement. For some children, who are perhaps too anxious or preoccupied, activity and action are their ways of expressing as yet unformulated thoughts and feelings (Danielle’s restlessness or Kenneth’s distractibility). This may be described by those caring for the child — parents or teachers — or enacted in clinical encounters.

Some children experience anxieties in their bodies, through physical symptoms or pain, or express disturbance by physical means such as bed-wetting or soiling [132]. Adolescents too may express themselves through the way they dress, wear their hair, through piercing parts of their body, or through cutting, self-harming or in complex ways in relation to eating.

Often, experiences of loss can be expressed by children in a diffuse way — by falling or by dropping toys or throwing them away. Similarly, a feeling of being uncared for may be expressed by the child’s appearance or their own lack of care of clothes, books, toys, etc. Children who have been abused or neglected may well have missed out on the experience of being with a parent who could consider their feeling states, help the child to identify what they are feeling, name it, respond or modify it. That is, children may be deprived of an experience of being with a carer who can help him make sense of what they think or feel. These children may, as a consequence, present as confused, or more likely to project feelings into others in an undigested way.

For children who have been sexually abused, even though they may not have a clear memory of their experience, in sessions attention may be drawn to sexual themes in their drawings or by the way they position themselves or move. This can seem like an ‘elephant in the room’ — everyone is aware of what may have happened, but feels uncomfortable talking about it. Although time might need to be given to thinking how you would address this, children also need to know that their communications, however anxiety-provoking, can be understood and discussed. See sexual abuse in Section 7.4.

For all of us, there is a tendency to want to ‘manage’ behaviour, but might it be possible to think about and respond to behaviour as a communication?

In this next section, we will present a number of examples of communication through play. The first example has the therapist’s reflection on the session. In the other example you will be asked to provide your own reflections.
Thomas
Thomas, aged seven years, had been referred to CAMHS by his social worker because of his unpredictable, angry and aggressive behaviour. For his second individual session, he was brought by his keyworker, Phil. Thomas had recently moved from a long-term foster home to two short-term foster homes (one for 14 days and the other for four days) before moving to a residential home where he was the youngest resident.

In this session, Thomas arrived firing on all cylinders. He began by playing with a soft ball that had been provided in his box. Soon this developed into kicking it hard, while asking what would happen if he smashed the camera, window, etc. At the point when the therapist felt most anxious about the room and whether she could contain him, she talked to Thomas about being here with her on his own, and suggested that it might be helpful for Phil to join them. Although Thomas continued to kick the furniture while running around the room, he gradually slowed down and briefly listened while his keyworker Phil told the therapist how anxious and unsettled he was whenever anyone visited, such as his social worker. While they talked, his keyworker and the therapist drew, and in time Thomas joined them at the table.

Thomas began drawing a rabbit with long ears. Tentatively, the therapist noted that Thomas had been using his ears to listen to what Phil and the therapist were saying, but that Phil had also used his eyes and ears to notice when Thomas was upset. When the therapist noted all the changes he had experienced, there was a pause before Thomas said, ‘It’s difficult for me to understand’.

Reflections
In this session, Thomas was testing how the therapist would react to his threats to damage the room, as well as demonstrating the very problems for which he had been referred. But he was also in a relatively unfamiliar place, separated from Phil (who was in the waiting room), and perhaps anxious that these interviews, like previous meetings, might herald another move. Perhaps, in such a situation, he might wish to reverse his position and unconsciously project or elicit fear in the therapist in order to protect a more vulnerable or frightened part of himself. By reflecting on these feelings, the therapist began to formulate the way in which Thomas may turn to activity and aggression as a defence against anxiety. Eliciting Phil’s help and noting the symbolic nature of Thomas’ drawing (the long rabbit’s ears), opened the door to Thomas and therapist thinking together. When Thomas’ fears were listened to and addressed, he could be in touch with his confusion (‘it’s hard for me to understand’). It would have been easy to jump to conclusions — to think Thomas wasn’t listening or to cut across his efforts to find his own words, either by asking a different question too quickly, or by filling the space (the long pause) with the therapist’s thoughts about what he might be feeling. Time and patience is needed to allow children to become engaged in the process of thinking and to express their feelings.
Lorraine
Lorraine, Thomas’ sister, aged five years and eight months, was brought to her first individual session by her foster mother, with whom she had been living for seven months. In this session, Lorraine made a plasticine snake which she said was ‘dangerous and looking for food.’ She used the snake to frighten the therapist, but when the therapist responded by pretending to be afraid, she claimed it was ‘only pretend’ and made the snake eat the rabbit puppet, which she quickly popped into her box.

The therapist asked Lorraine if she had ever been frightened. She replied ‘No, you ask mummy (meaning her foster mother) if I’ve ever been frightened’. When the therapist noted the six foster homes she had lived in, Lorraine corrected the therapist, ‘No, 100!’ But when asked if she could remember all her moves she had made, she replied, ‘No’. Within a moment after that, she said she was going to show her foster mother the snake she had made and left the room to return to the waiting room.

Think about what is happening in this session and what Lorraine might be communicating. You should make notes in your portfolio to discuss with your facilitator who may well have further thoughts on what is happening.

Adolescents can also make those around them feel like they are feeling – confused, useless or frightened, for example. These feelings can be very powerful and hard to locate as ‘belonging’ at some level to the adolescent. That is, adolescents often act out their feelings, which can seem at odds with what is ‘expected’ in therapeutic work. To stop, think, or reflect can put them in touch with conflicting points of view. Rather than experiencing internal conflict, these views can become polarised with adolescents, parents or staff all holding apparently opposing views.

5.5.3 Re-enactment
Some sequences of play seem to mirror actual experiences which are undigested, unresolved or unavaiable for thought. Re-enactment may be referred to when what is being dramatised or played out is reminiscent of an earlier experience. For example, an eight year-old girl repeatedly positioned her chair in a way that made her worker worry she would fall backwards against the wall and hit her head. In her birth family, she had in fact, been non-accidentally injured as a baby and admitted to hospital with a fractured skull. While Emma had no memory of this experience, her play in the room and numerous incidents at home and at school raised concerns about her placing herself in vulnerable positions where she might get hurt, often in the very way in which she had been hurt as an infant.

Relationships too may have the flavour of a re-enactment. A child may expect and elicit a negative or even an angry response to every encounter, perhaps recreating in the present an abusive relationship from the past. Children and adolescents can also make those around them feel like they are feeling – confused, useless or frightened, for example. See Section 6.6.2 on transference and counter transference.
**Lucy**

Lucy, a 15 year-old girl living in a residential home after having been rejected by her family, often refused to come to her sessions. The practitioner seeing Lucy in the CAMH service described feeling useless and uncertain whether to keep Lucy’s sessions open for her. Only gradually was he able to reflect on how rejected he felt and to wonder if this was how Lucy felt.

In the residential home, Lucy could be verbally abusive to staff, eliciting anger in them. Being understanding only seemed to inflame her, so much so that the staff felt she was literally ‘looking for a fight.’ At times, arguments broke out between her and some of the other adolescents in the home. Sanctions and punishments only added to the problem as she then blamed staff for picking on her. It seemed in these instances Lucy was caught up in re-enacting the relationship with her parents that had led her to coming into care — feelings of anger, as well as feelings of rejection, were to be held by the staff while Lucy claimed that no one cared for her.

Can you think of an example where you thought a young person was re-enacting something from earlier in their life? Make notes in your portfolio of what you thought was being re-enacted and how this was being displayed.

### 5.6 Reflecting on your experience

#### 5.6.1 As a child or adolescent

Earlier we asked you to remember and think about your experience as a child or young person. In part, all of us draw upon our experience to imagine what it might be like for someone else, but is it also possible to imagine how someone might have experienced a similar event very differently?

In a quiet moment, try to remember an incident in which you as a child had felt understood? Misunderstood? Can you remember going to an unfamiliar place, much as we have described a child’s first visit to a clinic? How were you helped or not helped in managing your apprehensions or fears?

#### 5.6.2 As a practitioner

Throughout this chapter, you have been encouraged to reflect on your work and your interactions, and to use yourself to establish and build relationships with children and young people.
Now consider a clinical situation in which the issues discussed or feelings elicited were similar to your own experience. Do you think your experiences helped you to understand the family you were seeing? Or were you concerned that your own experiences affected your judgment? Who would you discuss an issue like this with?

Reflecting on yourself and your work is not easy. An important part of developing skills in any new workplace is to share your thoughts and feelings with others. Gaining confidence in undertaking a new role may take time, but developing a capacity to think, reflect, to ask questions, and to be open to not knowing, are important qualities to learning. You will find a reflective model in Section 6.9.2, as well as a description of clinical supervision – a process which aims to help practitioners reflect on their experience with a supportive colleague.

**Recommended reading**


Chapter 6: Ways of understanding mental health

6.1 Introduction
WHO (2001) defines mental health as “a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” [24].

The young people who you work with have been referred because the referrer thinks they may have mental health problems*. When you and your colleagues try to assess what is wrong with a young person’s mental health, you endeavour to identify problems and find what might have caused them. Depending on the outcome of your assessment and ensuing formulation, you will plan a set of therapeutic interventions, which you will review from time to time, until the problems improve or disappear.

In this chapter we are going to start from the time of referral, collect the information that is necessary to assess children’s mental health and make holistic**, child-centred formulations. The importance of reflecting on the young person, the family, and the knowledge we acquire about them, cannot be understated. You will be guided to models of reflection and supervision to allow you to do this well.

6.2 Learning outcomes
This chapter should help you to:

1. familiarise yourself with common ways of thinking about mental health problems, their origin and possible solutions in order to make holistic assessments.
2. build a comprehensive formulation of what has been happening to a child/young person before referral and what the service will be able to offer.
3. appreciate the importance of therapeutic relationships to integrate and personalise the information that goes into planning care and treatment.
4. understand what a reflective approach means and develop reflective skills.

* The term ‘mental health problem’ is commonly used to describe difficulties in living, learning and relating which express themselves as difficult emotions and behaviours, and psychological and psychiatric problems. The more complex and severe these difficulties, the more specialised are the interventions they require. 24. Framework document, S., Mental Health of Children: A Framework for Promotion, Prevention and Care. 2005.

** Holistic: There are many ways of thinking about mental health (see Chapter 3), all of which offer a different perspective on mental health problems, their possible origin, and the kind of solutions that might be desirable. In this chapter we are going to call these different ways ‘models’ and look at some of them. While they don’t necessarily marry well in theory, they are often integrated in practice. The way to integrate them is to adapt our thinking to the needs of each child, young person and family and to reflect with them on what might be of help. Unfortunately, the range of help we can offer is limited by what is available locally — a consideration that must be part of our planning.
6.3 Assessment

Assessing a young person’s mental health means being familiar with several different models, all of which contribute something to the understanding of what mental health is, and how it can go wrong. Let’s take Kenneth’s emergency referral at the age of 16 as an example.

Example

Kenneth was referred to an out of hours CAMHS team by concerned staff at an emergency hostel. The staff had only known Kenneth for a few hours, but they were worried enough about his mental health to contact NHS24 and obtain a visit from an on-call team. Reflect on the following issues:

Kenneth had three presenting problems:

1. deliberate self-harm;
2. low mood; and
3. street drugs misuse.

The CAMHS team elicited several factors in Kenneth’s life which go some way towards explaining all three presenting problems. Here are these contributing factors:

1. Kenneth doesn’t have a place to live and he sleeps rough.
2. He has no living relative or adult to care for him.
3. His best friend and flatmate, Fiona, died recently.
4. He is depressed.

This story tells us something about the nature of mental health problems and their complex causes. Kenneth’s problems can be understood in several different ways, each of which offers both reasons why problems come about and potential therapeutic solutions. In the bullet points below, each bullet point highlights a way of thinking about Kenneth’s mental health problems.

Kenneth’s problems are:

1. Developmental: At 17, Kenneth should be in education, training for a trade, or working. A good peer group for him would be made up of young people embedded in society and positively involved in age-relevant, useful activities. They would help each other develop the identity on which they will base their adult life. Homelessness and constant drug misuse interfere with Kenneth’s development.

2. Social: He has no home and depends on the local authority for one. His residential placement has ended. He has lost his council tenancy, and these are hard to come by. Local authorities are responsible for social problems of this sort: Kenneth has a social worker, although she doesn’t know him well yet. She will be involved in trying to find Kenneth a home and some support.

3. Psychosocial: Kenneth has been bereaved and needs support and companionship. It is likely that this experience of loss will bring previous ones to his mind and make his grieving work more difficult. The accompaniment and support of a youth worker might help him.
4. **Family / systemic:** Kenneth doesn’t appear to have a family at the moment, but he will have a story to tell and a family in his head. It would be useful to learn about this narrative and its impact on Kenneth’s sense of self – it may demonstrate vulnerability and/or resilience in various ways. A family systems approach might also think about the network of relationships and systems that surround him, which would include his key worker at the hostel, his social worker, etc.

5. **Psychodynamic:** Kenneth’s attachment figures have disappeared one after the other since he was born. This experience repeated itself recently when Fiona died and he lost his home once again. Kenneth’s inner world must be an insecure place: what will his ability to trust be after this? A psychodynamic assessment might suggest a form of psychotherapy.

6. **Cognitive and behavioural:** Kenneth’s low mood may be triggered and maintained by negative thoughts he has about himself and his situation (‘I’ll never be able to keep a tenancy on my own’, ‘I couldn’t cope without the drugs’). A cognitive-behaviour therapist would help him notice these and change them so that he can take a more confident approach to his problems.

7. **Biological and medical:** Kenneth has several problems that could be identified as medical: he may need antibiotics for his wounds; he shows symptoms of depression. He may have other, undetected health problems, as many homeless people do. A medical assessment of his physical and mental health followed by a clear diagnosis (using ICD 10 or DSM-IV multi-axial classification) would be helpful. This would take into account neurobiological and genetic factors in addition to psychological and social ones.

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Find an example of your own among the young people you work with. Analyse this child or young person’s assessment, as we have just done here. You might find it more stimulating and enjoyable to do this with a colleague.

Discuss the results of your work with your facilitator.

Between them, the models offer a bio-psycho-social way of assessing mental health. Developmental and biological approaches were mainly discussed in earlier chapters (see Chapter 4). The next five sections of this chapter will describe further ways of thinking about mental health. All need to be considered during the assessment.

Several members of the multi-disciplinary team, with different professional expertise, may need to collaborate to obtain a comprehensive assessment (see Chapter 3 and Appendix 2).
6.4 Social and psychosocial ways of thinking about mental health

6.4.1 A social model
A social model of health focuses on the environment as the main cause of poor mental health. Social factors, such as poverty, isolation, poor housing, race, and gender, all affect health, including mental health. For example, a strong association has been found between mental disorder in children and young people and family income and social class [133]. *For Scotland's Children* highlights the social differentials that affect children in Scotland: one third of children are brought up in poverty and this seriously affects the outcome of their childhood [134]. A social model also takes account of cultural and ethnic factors.

Why do you think poverty, race or gender affect mental health? Think of three young people you have in your service at the moment for whom you think one of these is true, and explain why in your portfolio.

The family, as the smallest social unit, is affected by social trends. The proportion of families comprising a couple with their children is decreasing while the number of lone parent families is increasing. One child in four is brought up in a lone-parent family [135]. Lone parent families are more at risk of socio-economic disadvantage. They are usually headed by women, who themselves have poorer mental health than men. Families tend to depend on two incomes, which means divorce has a strong economic impact on them. When they divorce, women who are mothers are on their own for an average of four years at a time.

Almost half of women with children under five are now in employment, although mainly in part-time employment. In the 1990s, the cost of having a child was evaluated at around £3,000 a year [136]. This cost is born by women more than it is by men. The cost of having a child has been estimated to diminish a woman’s lifetime earnings and pension by two thirds.

If our society attended to socio-economic disadvantage (instead of letting the gap between rich and poor widen [135]) and social exclusion (of disadvantaged and minority groups), the rate of mental health problems in children would improve substantially [134].

Read the story of Kenneth again, starting with his mother's pregnancy. List all the social risk factors for poor mental health in Kenneth's life.
6.4.2 A psychosocial model
A psychosocial model remains focused on the environment but is more embedded into people’s own lives and interpersonal context. An assessment of children and young people’s well-being has to include their emotional environment, and the kind of care-givers they have and the relationships they have developed with them. For older children, this involves the school and the peer group. Factors like abuse and neglect, bullying, and less visible interpersonal difficulties — none of which are specific to economically disadvantaged households — are detrimental to mental health (see Section 5.3.4).

Now, list all the psychosocial risk factors for poor mental health in Kenneth’s life. Try to disentangle social and psychosocial factors.

Using social and psychosocial models of mental health
The social and psychosocial circumstances of children and young people referred to our services must be assessed in order to detect those which may have played a part in their current difficulties. In turn, this may guide us towards useful interventions.

Scenario example
Jane is 13 and has not been going to school regularly for several months. She has been referred by the GP because of her high levels of anxiety. During the assessment, which she attends with her mum, you begin to suspect that Jane’s mother is abused by her partner verbally, physically and possibly sexually, and that Jane stays at home because she is worried about her mum.

What would you do? Discuss it with colleagues and your facilitator

6.5 Family/systemic ways of thinking about mental health
Children’s growth and development in the family, the family life cycle, and practical issues for consideration when meeting a family were dealt with in Chapter 4. In this section, the main concepts of systemic thinking will be introduced, and we will point you towards other texts to develop your knowledge further.
From before they are born, the family contexts of children differ. Some are embedded within stable communities, perhaps with grandparents and extended family members, while others have experienced increasing or sudden changes in their circumstances (possibly through migration or having to seek refuge [137]). Culture influences the way a family develops, e.g. a family from an ethnic minority may have different factors affecting its development. The main point is that all influences are taken account of. Some families live at the heart of their communities, whether traditional or evolved, while others experience social exclusion and fall back on their own meagre resources. This impacts upon children directly, or through the well-being of their parents whose central role is to provide them with a context of relationships to develop and thrive.

Think about your family of origin. What kind of family was it, traditional or affected by modern social changes? What kind of community was your family embedded in?

All the models which offer ways of understanding young people's mental health needs are compatible with a family approach. Family therapists have demonstrated and argued that a systemic assessment is always beneficial (see Chapter 4). Systemic thinking makes it possible to map a child's links to the groups (or systems) to which she belongs, like a series of concentric circles (see drawing below): her nuclear and extended family, her community / neighbourhood / school, her friends and the wider social, cultural and economic network [138].

Figure 2: Drawing of the systems in a child’s life
(adapted from Carter and McGoldrick 1999) [75]
The only issue that varies from child to child is the weight to be placed upon family and systemic factors, and how far to include family members in treatment.

Choose a child or young person you work with and draw a genogram (see Section 4.4.3) of her/his family and wider systems. What additional information have you collected in this way? How might it be used?

**Culture**

Culture has a major influence on the functioning of families [99] and must always be taken into account in systemic assessments. Patterns of communication, for example the way people share feelings or concerns across gender and generations, are affected by cultural values [139]. Child-rearing practices in Scotland can vary greatly due to the increased diversity of ethnic groups. Cultural influences on family values, gender roles, etc, are communicated and transmitted in many different ways, both explicit and implicit. Cultural differences can bring dramatic differences in the experiences of children and young people.

Discuss with others how you see the differences in experience between the following children and young people:

- A second generation immigrant 16 year-old Pakistani boy in Glasgow.
- A newly arrived six year-old Polish girl at school.
- An 18 year-old Zimbabwean student with post-natal depression and her baby.
- A 12 year-old Scottish boy at his fee paying school.
- A refuge-seeking Iraqi family living in one room.

Imagine how your service would take into account the cultural needs of each child, young person or family.

Systemic thinking also offers guidance and a set of principles to assess a family’s structure and functioning. The concepts which underpin it evolved from observing families in communities [140]. These were later refined through working with families in clinical settings.

**6.5.1 Summary of the important dimensions of systemic and family thinking**

Some of these are described here. It is the goal of assessment to find out how each of them applies to a newly referred family. You will find good information to complement this section in Carr 2000 [36] or Dallos and Draper 2005 [86]. Skynner and Cleese (1990) is an excellent (and humorous) introduction to the subject [141].
**The whole is more than the sum of the parts**

This is a key idea. The sum of the parts in a family – the sum of members' individual characteristics – gives an inadequate understanding of what constitutes a family. It is the matrix of relationships that individuals form, or find themselves in, that may be the key to individual functioning and well-being [86]. This is also true of other social systems (for example clinical teams). Family dynamics can be helpful or unhelpful to an individual family member: talents can go unrecognised or under-utilised, an individual child can become the carrier of the family's grief, vulnerability, anger, etc. Conversely, family support and strength can get individuals through difficult periods in their lives. Therefore the family can bring risk factors into a child's life (for example insecure attachment, inconsistent discipline, chaotic organisation) or protective factors (secure attachment, clear communication, supportive interactions) – for further elaboration of this, see Carr 2006 [142] p66 and Rutter 1998 [63].

For this reason, it is essential to understand the emotional climate of families.

**Homeostasis**

This has been, and continues to be, an influential concept in systemic thinking, yet it is by no means original. ‘Homeostasis’ simply means the tendency of a system (whether mechanical, biological, social, or psychological) to assume a steady position and to revert to it quickly after the position has been disturbed (the surface of a pond settling after a fish came up to catch a fly; re-growth correcting asymmetry after a plant was pruned; new ideas introduced to a professional group quickly forgotten in favour of well-established ways of working).

Families may struggle to overcome sudden events or losses (such as major illness, economic loss or death) and try to recapture their earlier ideas about themselves. Finding an alternative identity, more adapted to circumstances, can take a long time. Yet changes are inescapable for families: children are born and their development is punctuated by change (going to school, taking part in sports, making friends etc), which impacts on their parents and siblings. Levels of activity, intimacy, support needs, interactions outside the family, alter in keeping with the maturation of family members.

In clinical work, homeostasis is most evident when the family is encouraged to make changes to their usual transactional patterns. For example a family, where quarrelling had been the habitual way of dealing with feelings of loss and depression, started to quarrel again at the end of a session where these feelings had been openly discussed for the first time.

One of the best ways of understanding a social system is perhaps to observe what happens when you try to change something. What systemic thinking would be seeking to explore is “what difference would make a difference?”

Look out for examples of homeostasis in systems that surround you (social, clinical and others) and note them in your portfolio. If you find this difficult, discuss it with colleagues and your facilitator.
Systems and sub-systems

Sub-systems are the various constituents of the larger family system: for example, a sibling group, a marital subsystem, and sometimes the close relationship grandparents establish with grand-children who live nearby.

Differentiation is necessary within a system. Most systems, whether family or workplace, are hierarchical in at least some respects (which means there is an uneven distribution of power, opportunity to delegate, direction of accountability, etc). Boundaries define and contain systems and sub-systems.

Boundaries

Boundaries define who participates in the various sub-systems, and how participation is enacted. For example a mother may reinforce the boundary that separates the parental and sibling sub-systems by not allowing one sibling to discipline another. Boundaries can be clear, diffuse, rigid or over-involved. The development of interpersonal skills in children and young people requires boundaries to be clear. Hence, parenting is most effective when children or grandparents do not intrude into the parental sub-system. Effective peer relationships require non interference from parents.

Boundaries must be preserved to maintain optimal functioning and to minimise the possibility of an unresolved issue in one sub-system disrupting the functioning of another. Marital problems intruding into parenting behaviour, or children disrespecting one parent to meet the silent approval of the other, are example of poor boundaries between two sub-systems.

Communication

Good communication is important for good system functioning. To be good, it must be both clear and direct and it must be listened to [86]. Impaired communication is a high risk factor for mental health problems, the direction of influence probably being circular rather one of cause and effect. The adverse effects of high Expressed Emotion (High EE) [143] are one example of this. Exploring a family’s communication patterns is part of most family assessments, and facilitating more effective communication is part of most family therapy sessions.

The enmeshment – disengagement continuum

This concerns the emotional bonds apparent between family members, from over-involvement (enmeshed) to under-involvement (disengaged). Enmeshed families can be costly to individual members whose autonomy becomes compromised by over-involvement with other family members. At the disengaged end of the continuum, only extreme stress in one member is noticed by the others. Attachment influences this, as do cultural factors [144].
Environmental fit
Despite growing up in the same family and sharing the same genes, children’s experiences can be very different [62]. This may be due to the influence of genetic factors, environmental differences (such as the relationship with the main caregivers) and circumstances. Therefore the family ‘niche’ of each child will be different, and the difference may increase with time. As a result, the ‘environmental fit’ that each child will require to thrive will also be different. By adolescence, the needs of siblings may differ sharply.

Find out from colleagues in your outpatient team how they explore the environmental fit of a child or young person when they do a family assessment.

Family stories
The thoughts and beliefs families have about themselves are now recognised to be important influences on how problems are viewed and coped with [145]. For example, “this is something that Dads never understand: a lassie always needs her mother”, will shape the perception of how new support needs can be met; and the family will use it to explain to themselves how past issues were successfully resolved. Not all family members would necessarily hold to the belief (asked about his opinion, the father in this family might strongly disagree with it: “but no one listens to me”). The exploration of difference, of apparent contradictions, is all part of a narrative approach which informs family therapy [146]. It is through listening to their stories, clarifying where necessary, that the lived experience of each can be understood, not so much from what they say they experienced as how they interpreted their experience.

6.5.2 Who to work with?
Some family members are notoriously poor at attending family meetings: fathers and adolescent siblings among them. Who should you try to engage with and when does family work cease to be family work? Robin Skynner (1990, p5-19) suggests meeting with what he calls a minimum sufficient network. “The minimum sufficient network represents the minimum number of individuals in the nuclear or extended family which must be involved in therapy if therapeutic change is to be possible” (1990, p8) [147].

In the following scenario, work out whom, in your opinion, constitutes the minimum sufficient network.
Scenario

A 6-year old girl: behaviour problems
Younger sister: has cerebral palsy
Single-parent mother: husband left her shortly after birth of the younger daughter
Maternal grand-mother: widowed, recovering from a stroke
Aunt: a social worker who returned from London to help out when their mother had a stroke, then gave up her job to work locally to be available to the family
The six year-old’s school teacher: concerned about her immature, sometimes erratic, behaviour
Health visitor: piled in a lot of support in the early years, now reduced
Paediatric nurse: used to see them regularly at the hospital, occasional visits to home
GP: prescribes an antidepressant for the girls’ mother
Physiotherapist: sees the younger sibling weekly
The two sisters’ estranged brother: lives in Elgin, with a young family of his own

Although a child or adolescent may be the ‘identified patient’ the referral may be one way of drawing attention to problems in the wider family system or subsystem, such as marital problems between the parents. Then, thought might be given to working with the couple.

Sometimes a systemic assessment might be followed by the decision to work with a child or a young person individually. Even then, it is important that this decision be arrived at while considering the whole family, because a child must always be understood in a context — that is, embedded in overlapping systems. Furthermore, the decision to work with a child alone, or with child and parent in parallel, is best taken together with the family, in answer to the question: ‘how can the problem (whatever it is) best be addressed?’
**Children living outside family structures**

Children whose care has been entrusted to a local authority may not be living with a family, although many have foster families [148]. However, these children are embedded in complex systems where their own family of origin overlaps with other care systems, which include a social worker, a key worker for those in residential care, foster families (often more than one, chronologically). For many, relationships with members of their original family remain, however fragmented and unsatisfactory these are. Assessing the contribution of these various systems and people, how they relate to each other and think about the child, is essential and systemic thinking is the right tool to do it. For the child or young person, a change in context often means a change in the relationships and roles they have been used to here: one in five siblings in the family of origin becomes an only child in the foster family; a girl among boy siblings acquires two step sisters; the eldest child becomes the youngest child…The young person may need help to adjust to such changes.

Working with families can take different forms: family therapy may be advisable if the family’s relationship problems are severe and impact significantly on the referred child [36]. Although formal family therapy has evolved as a distinct type of work in its own right, in practice it may sometimes draw on other now well-described approaches, for example cognitive therapy [149], psychodynamic ways of working [150] and solution-focused therapy (www.brieftherapy.org).

Systemic thinking has been widely used in family therapy, but it is useful even when family therapy is not anticipated (for example, when the main focus of CAMHS work is on supporting parenting skills, or supporting school-based counselling).

Systemic work can also take the form of parenting programmes [151-153]. Parenting programmes have been shown to help parents who struggle with their children’s upbringing. They aim to enhance children’s resilience and in some cases [151] focus especially on children under eight who have behavioural problems. They target young families.

Working with families also means simply keeping in touch with them and providing them with support, information, advice and a listening ear as required [88]. This alone is highly valued by parents, as every survey of service satisfaction indicates. We will discuss this further in Section 6.8.3.
6.6 Attachment and psychodynamic ways of thinking about mental health

6.6.1 Attachment theory

The theory of attachment as a process of universal importance arose from the study of children separated from their care-giver. It is based on direct observation of infants and their parents. Together with the Robertson [154], Bowlby [112-114, 155] studied the reactions of children admitted to hospital at a time when very little contact with parents was allowed. During the course of their observations, they identified and described three stages of response to this separation: protest, withdrawal and detachment. They discovered that, without mitigating circumstances such as regular visits from parents, or the availability of familiar comforting objects such as teddy bears, the stability of the children’s relationships with their parents was affected, often for longer than anyone had realised or expected.

Bowlby formulated a theory of attachment, proposing that all children need secure attachment to their primary care-givers to be able to explore the world and form relationships with other people.

Read Jeremy Holmes, 1993, Chapter 6 [156].

Attachment behaviours (a term that refers to the child’s responses at the point of separation or threatened separation from an attachment figure and the efforts the child makes to seek proximity to that person) were studied by Mary Ainsworth. She developed a tool, commonly known as the Strange Situation, for use with 10-12 month-old children, which identified three attachment patterns: secure attachment, avoidant attachment, and ambivalent attachment [157]. A fourth pattern, demonstrating a highly disrupted attachment experience, was identified later as disorganised/disoriented attachment; this is characterised by contradictory behaviour patterns, interrupted movements or unusual postures. Once established, these patterns have been shown to be very stable. Nonetheless, they are not so fixed that some change in response to changing circumstances is not possible.

Kenneth experienced several separations and losses during his 17 years of life. Discuss with your facilitator, or someone in your service skilled at attachment work, how the CAMH services Kenneth came into contact with might have helped minimise the effect of these experiences.
Internal working model
Applying attachment theory, Bowlby developed the term ‘Internal Working Model’ to describe a cognitive and affective ‘map’ of self and others built, over time, through a child’s interactions and relationships. This map, based on the child’s experiences, shapes the way he anticipates, predicts and relates to the world. For instance, securely attached children generally expect others, both adults and children, to be responsive and relationships to be reciprocal. They have a view of themselves as worthy of positive regard and affection. But children who have been on the receiving end of adverse experiences may find trusting others more difficult. Because our assumptions about ourselves and others, based on our internal working models, are relatively stable, they can have a lasting effect on our relation to the external world.

Discuss with colleagues the way in which Danielle’s early experiences may have impacted on her inner world as you see it expressed in her interactions with others and in her play.

Intergenerational transmission
Intergenerational transmission refers to a transfer of attachment characteristics and experience from one generation to another [158]. There is much evidence that the way parents or carers were cared for and related to affects the way they care for and relate to their child. The Adult Attachment Interview (AAI), devised by Main et al [159], allowed a systematic link to be made between the attachment status of a parent, usually the mother, and the attachment status of their baby. The AAI is a semi-structured interview in which individuals are asked to talk about and reflect on their past and present emotional life. Rather than what they actually say, it is the way in which they answer each questions — coherently or inconsistently, comfortably or superficially — that might reveals most about the extent to which they have been able to resolve and reflect on their experiences.

Such capacity to reflect on oneself, and to monitor how one is responding to challenging circumstances, is now considered central to psychological well-being. The term meta-cognitive monitoring has been coined for this ability to think about one’s own thinking, feelings and emotions. Thoughtfulness, or self-reflection, gets handed on [160, 161]. In clinical work, it can often be seen that those parents who have a capacity for self-reflection, and have been able to resolve even difficult or painful experiences, are less likely to pass these experiences on to their children. But parents who have not dealt with their own distress and anger may find it difficult to deal with negative emotions in their child. This failure in containment (see Section 6.6.2) may force their child to manage their own negative emotions.

Think about a family you are currently working with where you feel aspects of the parents’ life experiences remain ‘unresolved’- what are they? What impact does this have on the referred child? What work do you do with the family?
Attachment theory draws our attention to the importance and uniqueness of interpersonal relationships. This applies to the clinical setting, and must inform all our encounters with children, young people and families. To them, we are not just interchangeable professional roles. If they come to trust us, we become important to them and we need to bear in mind issues of attachment, separation and loss within therapeutic relationships. This means that continuity of care is important: children and families must have key people to relate to who are available, consistent and predictable; they need to be given time to attach to and separate from significant workers, and beginnings and endings must be managed sensitively [162].

In your service, what do workers do when they go on holiday? When are young people / families told? How are they told? Do they have a chance to say how they feel about it? Discuss this with others and with your facilitator

6.6.2 Psychodynamic ways of thinking about mental health

The main advantage of thinking about children and young people in a psychodynamic way is that it offers an understanding of their inner world and subjective experience – something that none of the other models do to the same extent. Section 5.5 is an example of this.

Sometimes children and young people with emotional and behavioural difficulties particularly struggle to make sense of what is happening to them, not only in the outer circumstances of their lives but also in their own feelings and behaviour. When they turn to us for help, they expect us to help them succeed: a working knowledge of psychodynamic ideas can be of great practical value.

Psychodynamic ways of thinking are based on the ideas that all behaviour has meaning and that some aspects of our experience may be unconscious and therefore not easily available for thought. Central to psychodynamic thinking are firstly the idea of anxiety, and secondly the idea of defensive mechanisms that may develop to keep the anxiety at bay. Although useful, or even a necessary protection in adverse circumstances, defensive structures can also be rigid or maladaptive.

Before you go on, it would be helpful for you to read section 1 of Bateman et al (2002, pp 1-63)[163] to increase your understanding of psychodynamic issues.

We will now explore a few key concepts that are particularly relevant to working with children and young people.
Containment

A baby’s physical, intellectual and emotional experiences are all linked. When these experiences are mediated by someone who can respond to her need for love and understanding, the infant will gradually begin to take in a feeling of being understood, and she will develop her own capacity to understand herself and others. In this way, many primitive anxieties, like fears of starvation, falling, or being left forever, are modified and modulated by the infant’s primary care-giver.

Bion used the term “containment” for this experience: overwhelming feelings are projected into a “container”, in this instance, the baby’s care-giver. If they are received and fed back in a more digestible form, they are contained — an emotional equivalent to being physically held in a comfortable and reassuring way.

Containment can go wrong in subtle ways. The baby’s projections of distress may increase the care-giver’s anxiety, or the care-giver may be preoccupied, depressed or in some way unavailable to receive the infant’s projections. If this happens, the infant’s feelings are not being understood and responded to in a meaningful way. This constitutes a failure of containment, which could be:

1. intermittent (and uncharacteristic of the relationship between mother and infant);
2. specific (that is, the parent may have difficulty containing certain anxieties and not others — see “intergenerational transmission” above); or
3. pervasive (the care-giver may not be able to contain the infant’s anxieties) [164].

In Danielle’s case, her birth mother had been observed to be reserved and emotionally detached. How would you imagine and describe the quality of containment available to Danielle prior to her removal at three years? Make notes in your portfolio.

The concept of containment was developed in relation to early relationships, but it can be applied usefully to therapeutic work. When working with children or young people, staff members may have the experience of feelings being lodged within them, sometimes in powerful, apparently inexplicable ways (projection; see defence mechanisms in Bateman et al 2002 [163]). These feelings are experienced as personal, but actually belong to the child/young person and not to the staff. Reflecting on these feelings may offer insight into something experienced by the child which would not otherwise be talked about.

Containment is not a passive process. The containing care-giver or member of staff must make the effort to remain emotionally available, to notice, remember, understand, to note congruity or not between what is said and the accompanying affect, and to differentiate between her own feelings and what the young person communicates (often non-verbally). It is a very active process.
The child's inner world
A child’s inner world grows from the very beginning of life, with unconscious fantasies accompanying physical experiences such as feeding and excreting, interactions and relationships. In this way the infant feels that people and events are active inside him, and can affect him and be affected by him. Young children’s perception of reality can be very different from that of adults. When working with them, it is important to be aware of this fact and to remain open to their way of thinking and the strength of their feelings, which may not be what we would expect.

Children’s anxieties may not be readily observed or overtly expressed. They may need to be deduced through observation of interactions with others or through play, drawings, etc.

A child’s inner world and imagination as well as her sense of security and actual relationships can come together in a way that causes internal conflict, anxieties and defences. One fantasy that may offset children’s irrational fears is that of an ever-present idealised mother or parents. But no parent can be available at all times, nor should they try to fulfil all their child’s wishes or needs. In moments of frustration, idealisation can crumble and the child can feel full of hatred, their loving parent suddenly transformed in their imagination into a witch-like persecutory figure. This splitting of people and experiences into good and bad is part of ordinary development. Over time, when circumstances are ‘good enough’, children learn to experience love and hate towards the same person, to tolerate strong contradictory feelings and still preserve their relationship with their care-givers, both internally and externally.

The pain resulting from the limitations imposed by reality can feel intolerable to a young child and lead to feelings of anger, grievance or fear which may impact on their developing inner world. If ordinary anxieties are compounded by experiences of actual abandonment, abuse or trauma, this may have profound consequences for a child’s capacity to trust and to establish secure relationships (See 5.3.4).

Read again the story of Danielle and pick out some of her puzzling behaviours. Does she give any clues as to what might have been going on in her inner world?

Transference and counter-transference
In psychodynamic therapy, the work takes place in the context of a relationship. This means that establishing a therapeutic alliance is a key priority, and the nature of the relationship between the child or young person and the therapist is the focus of attention. Children and young people are likely to behave towards a therapist or other members of staff in the way that they have been used to behaving with adults close to them. In this way (rather than by telling you directly), they reveal a lot about their inner world, their ability to trust, and the kind of anxieties they have. Transference is put to therapeutic use when the therapist helps the child make sense of the way he relates.
Counter-transference (the mirror image of transference), is the name given to the feelings the therapist experiences in response to a child or young person’s projection (for instance, irritation, or a wish to look after the child). These feelings can help understand how the child is feeling at that particular time, his unspoken needs.

What might you have felt about Danielle’s exploration of the room, when she found dust in the under-stretchers of the chairs and lost papers under the desk? How would you have responded to her?

Using attachment theory and psychodynamic thinking
Attachment theory is useful to understand a child or young person and to guide all interventions. Therapeutic interventions aimed at working with attachment problems directly are increasingly available (see [165, 166 or 167] for a bit more in depth information).

Assessing a child’s difficulties in a psychodynamic way may lead to a suggestion of psychotherapy but the understanding thus acquired may also be used simply to enhance communication with the child and the family, even in the absence of psychotherapy.

6.7 Cognitive and behavioural ways of thinking about mental health
Cognitive behavioural approaches to mental health problems and their treatment are underpinned by social learning theory - what we know regarding the way people learn about social behaviour. Social-learning theory is concerned with social interaction and builds on the fact that people, like animals, learn to use patterns of behaviour that are rewarded by their environment. Those behaviours that produce negative results are abandoned in favour of those that are reinforced by success. Social-learning theory also takes into account internal cognitive processes: people learn from their behaviour because they can think about what they do, foresee consequences and change their behaviour accordingly. Thinking and behaviour are also linked to feelings: these processes mutually influence each other.

Cognitive and behavioural forms of therapy use techniques based on learning to bring about change. It is assumed that prior learning, perhaps combined with new circumstances, is causing distress and maladaptive behaviour. Therapy offers ways of undoing this learning by helping people to explore their thinking and behaviour and detect those processes which are unhelpful to them. More adaptive learning experiences are planned so that new ways of thinking and behaving can be substituted. There are several types of therapies based on social learning theory: Behavioural Family Therapy [168, 169], some parenting programmes like the Webster-Stratton approach to children who show difficult behaviour [151] and Triple P [152], social skills training – both individually and in groups - and more. All focus on the difficulties encountered by people in the present and work collaboratively with them to bring about helpful changes in their lives. In this section, we are going to focus on individual Cognitive Behaviour Therapy (CBT).
6.7.1 Cognitive Behaviour Therapy (CBT)

CBT draws attention to the power of thought. Thoughts are evaluated for their implications, the evidence for and against each and in the light of alternative ways of thinking.

Although negative thinking styles (see below) are targeted, CBT does not advocate the power of positive thinking: if a negative thought is valid, it will withstand analysis; if not, a balanced alternative can be established. The evaluation of thoughts is always carried out from the patient’s perspective: “The aim is not to persuade persons that their current way of looking at the situation is wrong, irrational, or too negative; instead, it is to allow them to identify where they may have become trapped or stuck in their way of thinking and to allow them to discover other ways of looking at their situation” [170] p49.

There are three levels of thoughts on which CBT may work [171]. Negative Automatic Thoughts (NATs) are superficial cognitive structures and the more easily accessible of the three. They can also come to mind through images (you meet an ex-classmate in the street, she looks good and tells you about a great diet she has been on; you immediately feel shabby and an image of yourself as fat comes into your mind). Schemas are enduring patterns of understanding constructed over years. They can be difficult to access because we are not normally aware of them. They often include a lot of ‘shoulds’ (‘I should love my family’, ‘boys should always be good at football’). Investigating them may involve exploring aspects of the past. Core beliefs, which underpin our mental map of the world, are deeper still (see Internal Working Models, in Section 6.6, for a link to Attachment Theory). All of them can be maladaptive and the deeper levels can put brakes on surface change, so CBT may investigate all three, but it tends to focus primarily on NATs and the defensive behaviours which arise from them.

Read about cognitive child development in Piaget 1975, Schaffer 2004 or Gross 2005 – or any good psychology textbook [7, 172, 173]. Make links between it and the cognitive aspects of therapy described above.

Negative thinking styles

These are enduring ways of thinking – at the schema level – which reveal errors in the assumptions a person makes regarding situations and experiences. In turn they influence NATs and lead to unhelpful, mistaken conclusions. Here are examples of them:

- All-or-nothing / black-and-white thinking: if something is not perfect, it is a failure (“If my hair is not perfectly straight, I am going to look a mess”, “if I don’t get the answer right, people are going to think I’m stupid”).
- Over-generalisation: generalises one negative experience to all similar experiences (from “I found it difficult to do this maths exercise” to “I am no good at maths”).

Schemas are stable knowledge structures which represent all of an individual’s knowledge about himself and his world. They are made up of beliefs and theories about other people, oneself and the world in general. They will therefore affect what aspects of a situation we attend to, which we encode in our memory and how we interpret them” 171 Blackburn, I.M. and K. Davidson, Cognitive Therapy for Depression and Anxiety. 1995, Oxford: Blackwell.
• Mental filter and discounting the positives: picking out the negative characteristics of a situation and discounting the positives (a colleague praises the work you’ve done but points out one mistake and you conclude it was not very good).
• Jumping to conclusions: anticipating a bad outcome before starting something.

There are other negative thinking styles. Make a list of all the ones you can find from Burns (1999)[174], the website www.depressioninteenagers.co.uk or other resources.

NATs are sometimes called ‘hot’ thoughts – thoughts associated with strong affects (feelings). Hot cognitions are closely connected to behaviour: they trigger unhelpful self-protective behaviours and result from them. The interconnection between thoughts, feelings and behaviours (with the addition of physical sensations and environmental issues which are also involved) has given rise to the ‘Hot Cross Bun’ model below.

**Figure 3: The ‘Hot Cross Bun’ model**

<table>
<thead>
<tr>
<th>Thoughts</th>
<th>Physical sensations</th>
<th>Feelings</th>
<th>Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Environmental issues</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CBT sets out to assess, and if necessary support change in the five interconnected areas represented by the ‘Hot Cross Bun’ model.

Connections between these areas are sought, starting with the one that makes most sense or is the most disruptive to the young person. For example, one young man with a strongly competitive, rugby-playing identity became injured, lost what he perceived as his outlet for tension and his main source of pleasure, lowering his already depressed mood further. The injury also left him more socially isolated temporarily and increased his negative thinking regarding himself and his abilities. In this case, the physical sensations were the most immediately disruptive element, but they were affecting this young man’s behaviour, which was affecting his feelings and his thoughts about himself. The first intervention decided upon was to increase his social behaviour.

Taking an overview of the five areas allows for imaginative, collaborative interventions and increases choice of treatment options. It is also thorough, and allows for the exclusion of ‘ordinary’ reasons for difficulties (for example the investigation of physical problems if necessary).
Diaries and thought records
Keeping a diary can help detect NATs and negative thinking styles. Young people are asked to keep a record of target difficult behaviours, together with the feelings and NATs associated with them (a young woman who binge eats will record the situation, feelings and NATs that preceded a binge-eating episode). This helps to increase awareness of NATs and their association with negative feelings and unhelpful behaviour.

As therapy progresses, young people are encouraged to look for evidence that supports these NATs and evidence that does not support them, and to challenge themselves to think more accurately [175] p110-111.

CBT therapists in your service are likely to have diaries they give young people to fill day by day. Making use of one (or of the Thought Record Worksheet given by Greenberg and Padesky), try to identify the NATs or ‘hot thoughts’ that occur around a behaviour of yours you have identified as unhelpful. Then look for evidence for and against your NATs. Doing this with a partner will allow you to support and challenge each other.

As with all therapies, repetition of new learning is essential for thinking styles to change.

6.7.2 CBT with children and young people
Working with children and young people requires an understanding of the developmental process. CBT emphasises collaborative work between the therapist and the child or young person and rests upon a shared vocabulary. It assumes that the child or young person’s cognitive development is sufficient to permit the exploration and challenge of ideas. This may be difficult for a child before the age of seven. The younger the child, the more fantasy-based and concrete the thoughts: when a child’s normal thinking is absolute, uncertainty demonstrates anxiety rather than thoughtful reflection [7]. However, CBT can be adapted to children as young as eight by making it more concrete [176]. Language that the child can understand must be used, adapted to the developmental stage of each.

The collaborative style of CBT is well suited to adolescence when adults can easily come over as bossy. It means therapist and young person can become allies in the objective search for troublesome cognitions and behaviours. Wilkes et al (1994) [177] recommend that the therapist includes members of the family and social system to assess what their expectations are and recruit their support for the young person’s therapeutic work.

Affects are important in CBT and young people may need help identifying their feelings and disentangle feelings from thoughts. The therapist has to be alert to affects coming over through non-verbal cues, behaviours, changes in appearance etc. Then a choice of feelings can be put to the young person. Examples from real life, such as ‘what was it like when your team won the football game?’ or ‘how did you react when your sister took your jeans without asking?’ can also help them identify simple feelings like happiness, anger, feeling low or sad.
Young people are prone to extreme statements, perhaps saying they are feeling ‘terrible’ or ‘hopeless’. It is important to bring some measure into this and to work out what they really mean. How do they know when they feel terrible? Do they mean sad, or angry? Placing the feeling on a continuum of one to ten is useful. What does it take for them to feel the opposite feeling? How do they recognise the feeling in other people? Using as many examples as possible is helpful [177].

With young people, targeting behaviour first can be rewarding: CAMHS practitioners have found that if you want a young person to experience early success and confidence in treatment, behavioural interventions are where to start.

Helping young people to identify how they can increase their activity levels is more enjoyable for them and it can lead to cognitive work. The other benefit of starting with behavioural work is that it allows for increased access to thinking. Young people can find it difficult to access their thoughts – even the most insightful of us can find it difficult to know what we are thinking! Often, therapists only access a child or adolescent’s thinking through their behaviour. Attempting to practise new behaviour, or re-engaging with old behaviours, is an effective way of challenging negative thinking [178] [176]. It is also much more interesting to children and young people than boring old thought records.

Read the case of Kenneth again and imagine that you are seeing him at the age of 14/15 when he leaves foster care and tries to settle in residential care. What do you think his thinking style might be? What types of Negative Automatic Thoughts might he describe? What would be the best way of discovering these? Discuss with colleagues who use CBT how they approach this type of work with younger children.

6.7.3 The evidence base
Cognitive therapy was originally designed by Beck (1976) to treat depression [179]. Since then there has been considerable empirical investigation of CBT for anxiety disorders, eating disorders and, increasingly, psychosis. The evidence is strongest for anxiety disorders and some eating disorder behaviours like binge-eating.

Anxiety disorders (NICE guidelines 22 - December 2004)
http://www.nice.org.uk/CG022
This is where the strongest evidence of CBT success lies. Although the NICE guidelines do not cover the treatment of children and young people, the evidence that CBT is an effective intervention for anxiety and panic disorder is strong (based on category A evidence).

Obsessive Compulsive Disorders (OCD) (NICE guidelines 31 - January 2006)
http://www.nice.org.uk/page.aspx?o=289817
CBT is the main psychological treatment offered to children, young people and adults.
Eating disorders (NICE guidelines 9 - January 2004)
http://www.nice.org.uk/CG009
The evidence that CBT (or any other form of therapy) is effective with anorexia nervosa is poor, but it is strong for bulimia nervosa and binge eating disorders in adults. It can be adapted to adolescents, although the evidence of effectiveness is weaker.

Depression (NICE guidelines 28 - September 2005)
http://www.nice.org.uk/CG028
For mild depression in children and young people, supportive therapy, group CBT and guided self-help (see later section) are recommended.

For moderate to severe depression, the evidence applies to adolescents rather than children under the age of 12. Individual CBT, Inter Personal Therapy (IPT) and short-term family therapy are recommended. The evidence in favour of CBT for depression is in the B category.

Look at one of the sets of NICE guidelines and note the difference between category A and category B evidence. In Scotland there are SIGN guidelines. Look at the website www.sign.ac.uk and see if there is further information about the effectiveness of CBT coming from that source.

There is a significant level of relapse in depression and a large group of people with chronic depression for which there seems to be little in the way of truly effective and evidence-based treatment. Interpersonal therapy (IPT) – another structured and time-limited therapy – has shown similar effectiveness to CBT [180, 181].

CBT is being adapted to take into account relapse and chronicity in depression by adapting the short-term model to include longer-term treatment possibilities and follow-up appointments. It is also adapting by adjusting the therapeutic relationship more closely to the needs of the client group and by looking into new avenues of treatment, for example the addition of mindfulness and compassion mind training [182, 183].

However, the evidence that supports CBT as an effective treatment to date mainly relates to the use of behavioural interventions and surface-level cognitive work. CBT works in a ‘top-down’ way and the evidence is more in favour of surface, here-and-now work – although schema-based work and the examination of core beliefs necessarily involve exploration of the past. Treatment can roughly be divided into two halves, the ‘top’ coming in the first half and the ‘down’ in the second half. CBT is structured, and expects results in about 12 to 14 sessions – except for serious depression.

Another aspect of evidence which is relevant to CBT (but also applies to other structured models) includes the fact that outcomes tend to be better when treatments are structured and the therapist adheres to a model [184].

CBT is often delivered in a stepped way, as mentioned in the NICE guidelines for anxiety, OCD and depression.
6.7.4 Stepped-care

Stepped-care is the systematic use of low intensity, evidence-based interventions as a first line of treatment. It is accompanied by monitoring and the possibility of stepping up treatment intensity to ensure therapeutic impact. A stepped-care model helps to ensure an efficient delivery of the psychological therapies, particularly CBT, the use of which remains limited by cost and a lack of available therapists. Such an approach relieves pressure on the specialist services [185].

A stepped approach to care follows approximately this pattern:
- Step 1: Recognition of the problem and diagnosis.
- Step 2: Treatment in primary care.
- Step 4: Review and referral to specialist mental health services.
- Step 5: Care in specialist mental health services.

Practitioners in primary care (GPs, counsellors, community mental health nurses and home support workers) are increasingly engaging with people who have symptoms of depression and anxiety without immediately referring them to specialist services. They follow a stepped-care model, which in many cases will include the use of self-help packages.

Self-help CBT

CBT can be packaged in such a way that people with mild mental health problems known to be responsive to CBT, like anxiety or mild depression, can work on their problems by themselves, or with only a little supervision.

Self-help comes in at step two of the stepped-care model. It is based on the use of books or computerised programmes which help people understand their psychological problems and learn ways of overcoming them by following the guidance offered.

There has been a NICE appraisal of some computerised CBT packages (CCBT). Unlike the NICE guidelines mentioned previously, which are in the ‘Clinical Guidelines’ section, this one is in the ‘Review of Technological Appraisal’ section.

Go to the NICE website (www.nice.org.uk) and find the CCBT Appraisal (Number 97).

There are examples of CCBT for young people on two websites / CD-ROMs designed for those who are stressed or depressed [186, 187]:

www.depressioninteenagers.com
www.stressandanxietyinteenagers.co.uk

These psycho-education packages are directly accessible to young people on the web (i.e. without referral). There is evidence that young people like to turn to the internet to find information about mental health. They like being given immediate feedback and encouragement without having to consult a therapist.
The CDs can also be given to young people to work through as part of a step-care approach. The effectiveness of the package will then be monitored by a practitioner but this will not require much of that person’s time. The packages have been well evaluated by young people, families and professionals.

To review your understanding of CBT, go to one of the two websites www.depressioninteenagers.com or www.stressandanxietyinteenagers.co.uk and browse. Try to see the websites as if you were a young person.

Using the cognitive behavioural approach
CBT can be used in many different ways, although the evidence base is not the same for all mental health problems. Even if you are not a CBT therapist, an understanding of young people’s difficulties as learnt – and therefore open to change in the here and now – is very useful and it can help us to take a hopeful perspective of even entrenched problems.

6.8 Biological ways of understanding mental health
This section is brief as relevant information has been covered in other chapters: as indicated in Section 3.1.1, it is important to integrate an understanding of the biological aspects of mental health problems with psychological and social factors in order to develop a holistic approach to understanding problems. Sections 4.3.1 and 4.3.2 cover the complex multi-directional interplays between biological and environmental factors during a child’s development from foetus to adolescent.

Biological factors include:
- Genetic vulnerability to mental health problems, e.g. genes have been linked to a number of disorders including schizophrenia, bipolar disorder and ADHD. A number of genetic disorders are associated with certain behavioural and psychiatric difficulties, e.g. Fragile X.
- Macro- and microscopic brain abnormalities, e.g. the structural changes found in schizophrenia allowed the understanding that it is a neuro-developmental rather than a degenerative disorder.
- Neurotransmitter abnormalities associated with affecting mood and thinking have been identified for several mental health problems, for instance depression, schizophrenia, addictions, ADHD.

These factors inter-relate so that a genetic vulnerability, when combined with environmental stressors, can result in changes to the structure and physiology of the brain and the development of symptoms. Alternatively, changes to structure/ function can be environmentally acquired, e.g. a child who suffers a brain injury who then develops persistent behavioural changes.
Consider the biological, psychological and social elements which influence the presentation of a child you are working with. How is your understanding of the child altered if you do not take one area into account and what impact might this have?

You will find further information on clinical neuro-anatomy, physiology and genetics in most psychiatric textbooks. We particularly recommend Stern et al [188].

6.9 Making a formulation

During assessments you will gather information that spans several of the models we have discussed. This in turn will suggest several different types of interventions. A first assessment always includes developmental, systemic, bio-medical and psychosocial perspectives while full cognitive-behavioural or psychodynamic assessments are usually postponed till later. The process of assessment comes to an end when the most significant aspects of the child’s problems have been clarified in a way that makes sense to the referrer, the child’s carers and preferably the young person too. It should be in keeping with the scientific knowledge available in the literature. However, it is important to keep an open mind regarding the possibility of having missed significant data, and questions are likely to remain which can be laid out clearly for further assessment. Possible treatment goals are identified at this stage, options can be discussed and decisions made regarding desirable — and realistic — interventions. Like the assessment, the formulation will include the perspective of the child/young person, and that of the family who will also be involved in drawing up the intervention plan.

“A formulation is a mini-theory that explains why the presenting problems developed, why they persist, what protective factors either prevent them from becoming worse or may be enlisted to solve the presenting problems”[142].

6.9.1 Significant influences: the balance of factors in a child life

Among the factors that explain the presenting problems, some play a role in pre-disposing the young person to developing mental health difficulties, some play a part in maintaining them and some will have precipitated them. Protective factors mitigate the negative influences and promote a child’s resilience in adversity [142, 189].

Risk / pre-disposing factors and protective factors

These are mirror images of each other: high intelligence in a child is a personal protective factor while a low IQ is a risk factor; insecure attachment is a family risk factor but secure attachment is a protective factor; poor housing is an environmental risk factor and comfortable spacious housing is a protective factor.

Precipitating factors

Precipitating factors are acute life stresses such as illnesses, accidents, bereavements etc. or developmental transitions such as a change of schools, the advent of puberty, the birth of a new child in the family, etc (see Chapter 4).
Maintaining factors
Maintaining factors are negative aspects of a child’s life that make life more difficult: for example insecure attachment, coercive interactions and reinforcement of poor behaviour all maintain conduct disorders. These factors may equally interfere with therapeutic success unless they are neutralised in some way.

The resilience of a young person, however, is a more elusive concept: it seems clear that children vary in their ability to resist stress and adversity and that this resilience depends on a combination of factors (positive and negative, genetic and environmental). The likely resilience of a particular young person will be assessed by understanding the influential factors in their lives in conjunction with the adversity to which they have been exposed [68, 189]. See Section 4.4 on resilience.

Consult the list of influential factors found in Carr 2006: 42-3 [142].

Make an assessment of the same factors for Kenneth when he was 16, 14-15 and eight years old. How resilient is Kenneth? How would you assess this?

6.9.2 The views of the child/young person
So far, the assessment of Kenneth’s problems we have discussed so far has been professional-centred. In Kenneth’s story, we have already seen that he has a substantially different (and more positive) view of his drug use and self-harm. How can the two be brought nearer together?

Reflect on children or young people you have worked with since you came to this service. In what ways have such differences of understanding between the staff and the young person presented themselves?

You will be aware of how important it has become, in any work with children and young people, to involve them, inform them, consult them and encourage them to participate in all decisions that affect them. The original key driver of this approach, which is now assumed in all public policy regarding children and young people, was the UN Convention on the Rights of the Child, which the UK signed in 1991. Since then, this principle of participation has been enshrined in Scottish law, mainly through the Children (Scotland) Act 1995 (see Section 6.10.1 and HeadsUp Scotland 2005) [190, 191].

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Kenneth would need to be involved in the assessment process, as would a child of any age, and their views would need to be sought by someone they have begun to relate to - perhaps their key worker. You might also have some booklets about mental health, what causes mental health problems, and what can be done about them. This kind of information is useful, but it needs to be packaged in ways that are age appropriate, i.e. that a child can understand. Then it has to be discussed to make sure it has been understood. Resources for children and young people can also be found on the Young Minds website:[192] www.youngminds.org.uk.

Making decisions
As adults, we tend to underestimate children’s potential for making, or contributing to, responsible decisions, but with good communication (see Section 5.5) and good therapeutic relationship it is perfectly possible to find out what children, even young ones, think about what is going on and what they would like to see happening.

It is important to strike a balance between children’s and young people’s entitlement to be protected by adults, and their right to participate. The key to this is an assessment of their psychological maturity. Age and cognitive functioning are often used as sufficient indicators of mental competence, but emotional maturity (mental state, mood stability, attachment relationships, educational progress) and socio-cultural factors (family values, religious and cultural beliefs) are also necessary to determine a young person’s psychological maturity [193]. Such an assessment can help adults to reckon how much help a young person might need in understanding a decision and taking it. Younger children might express wishes that can be taken into account, while older ones might make their own decisions, perhaps with some support from their parents and expert advice from professionals. To be able to assess young people’s competence, however, adults must have a thorough knowledge of them, their world and the way they develop.

In the case of young people with mental health difficulties, mental state is an important component of their overall mental capacity. Young people who are acutely psychotic, or have severe anorexia or depression, can be temporarily impaired mentally, but this should not be grounds to exclude them from contributing to decisions regarding their care if they are able to express wishes which can be taken into account. Once their mental state is more stable, their ability to take decisions improves, so an on-going assessment of their mental capacity by someone used to adolescents with mental health problems is best. Even young people who have been compulsorily detained should be fully involved, so far as they are able to be, in all aspects of their care [194].

Discuss the following questions with your facilitator and with other colleagues:

Q1: In what way does your service include the young person’s views in its formulation?

Q2: In what way does it include the young person in decisions regarding the intervention plan?
Q3: It is helpful to have an explicit process through which this is achieved. Do you have one? If you don’t have one. What components should be included in it?

**Informed consent**

Children, younger ones in particular, can be brought to a consultation by their parents without understanding why, or what it means. Although parents can consent on behalf of young children, children of all ages need to know who you are, why they are seeing you, and what the purpose of the meeting is. They must give their own consent to it. So when you meet a child or a young person for the first time, it is important to check what they know and what they understand about their presence in the service, and to go on involving them from then on.

The consent children, young people and their families give to the therapeutic process is not a static thing and it may need on-going discussion. It is the basis of all collaborative work.

The legal position regarding informed consent is spelled out in the Age of Legal Capacity (Scotland) Act 1991, although this only applies to young people under 16 because those over 16 are legally adults.

Article 2(4) of the Act considers children and young people under the age of 16 to be capable of giving consent to medical treatment as long as they understand what is involved. In order to assess this, you need to be able to address issues of psychological maturity and mental capacity, as discussed earlier in this section under the heading ‘decision making’.

Read again the description of a CAMHS worker’s consultation with nine year-old Sean and his parents in Chapter 3. How is the issue of Sean’s informed consent addressed? How could it be improved?

**6.9.3 The views of the parents or substitute carers**

**What do parents/carers need?**

Research has shown that parents, whose children are receiving mental health care, particularly when these difficulties have been long-standing, need a great deal of help and support from professionals. They want to be listened to and understood, to be advised about the management of their child, to have mental health problems and their treatment explained to them, and to be involved in decisions regarding the young person. There is also evidence that they don’t always get this.

Families’ experience is that their son’s or daughter’s mental health problems can seriously disrupt their lives. Parents can feel vulnerable and guilty that they have not, somehow, protected their child, or that they have perhaps caused the problems.
A diagnosis of ADHD, or ASD, or bipolar affective disorder, or schizophrenia can be distressing, as parents have to face the loss of what they had expected for their child and settle for reality. The support they need then is to be accompanied in their grief. Siblings also need support to understand and cope with what is happening.

Sometimes children and young people manifest their difficulties through bad or dangerous behaviour, showing an inability to conform to social expectations. This can isolate their parents from relatives, friends and colleagues who don’t understand. So they need professionals to help them feel rehabilitated as effective parents in their own eyes.

This means parents or carers need to be involved from the assessment stage onwards. This is not always easy and it takes time. In practical terms, it means one or two members of staff becoming a family’s special worker, developing a relationship of trust with them, frequently setting time aside to meet with them, learning to know them, their difficulties and their needs. It means organising meetings at their request, in their own home or in the unit, perhaps with different family members at different times.

Some parents say that they are intimidated by the professional settings of CAMHS because the staff are knowledgeable and articulate [196].

Parents’ levels of social skills, mental health and ability to meet the staff half way differ. Some require more active, lengthy and skilful approaches than others.

Recent focus on children and young people’s rights seems to have led to a decreased involvement with parents (and carers in general — see confidentiality issues in Section 5.4.3). When parents and their children disagree between them or with the staff about the assessment or the formulation, skilful and patient negotiations are desirable, if difficult to carry out. Conflicts need not necessarily lead to relationship breakdown. They challenge everyone to maintain respectful and collaborative relationships.

Make notes in your portfolio about the last time you experienced a conflict of views:

- between the staff and the family?
- between the staff and the child/young person?
- between the parents and the child/young person?

How did your team work with it?

Once you have taken some time to think this through, discuss it with your facilitator.
6.9.4 The intervention plan

The provision of resources is uneven across Scotland, so it is unlikely that Kenneth would have access to all the possible or desirable solutions and forms of therapy.

There may be some professional wrangling around favourite therapeutic priorities. Go back to Section 2 for discussions of this issue. The priority has to be for professions and agencies to collaborate.

Don’t forget to build regular reviews into the intervention plan.

6.10 Integrating all the various elements

One of the challenges of the process of assessment, formulation and intervention planning is how to integrate all the information into a coherent and helpful whole. The key to this is to put the child/young person at the centre — all this work is for their benefit after all. The therapeutic relationship health care workers build with children or young people offers the context where each child or young person connects with the assessment process. Two or three workers will probably develop a close relationship with a particular child and the family. Some services have a designated worker for families to make sure there is plenty of time for them and their interests don’t clash with those of the young person [197].

6.10.1 The quality of the therapeutic relationship

Children and young people often find it difficult to be referred to a psychiatric service because it is a threat to their social identity. Some young people talked of this experience as profoundly stigmatising [198]. This can be compounded by long waits on waiting lists and in waiting rooms, shabby buildings etc. The quality of the experience they have once they have accessed the service can help to mitigate these negative aspects.

Rogarian qualities

Carl Rogers (1952) is known for his client-centred method of counselling [199]. Rogers’s client-centeredness developed after he researched therapeutic relationships. What he found was that all therapies, whatever their model, had an enhanced chance of being effective if they included a few key ingredients: a non-judgemental, positive attitude towards the client; warmth; respect; genuineness; and unconditional positive regard. With children and young people, such a relationship will be based on an awareness of their view of the world (see Chapter 5) and it will be consolidated in the context of clinical supervision.

Children and young people themselves have described a helpful grown up as someone who is empathetic, available, confident, understanding, who knows how to listen, is trustworthy, and powerful enough to make things happen [200].
What young people and children say they want is someone who cares for them. A piece of research done in in-patient units [196] showed that the relationships young people had with the people they met in the units (both staff and other young people) were what they found the most helpful. Some of them highlighted the contrast between the companionable quality of unit life and the incomprehension and stigma they had met before their admission. They reported that these relationships had a positive impact on their self-esteem. The most valued therapies were relationship-based and those interventions where there was plenty of collaboration and negotiation.

Culture
Children and young people are embedded in cultural groups born of ethnic origin, social class, family background, nationality, religion, etc… So are the staff. So skills to work across cultures are essential [201]. How sensitive are you to cultural issues?

Q1: What cultural group were you brought up in? Think of five defining characteristics of that group (these could be family traditions, rituals or religious practices, community activities, festivals, ways of spending money etc.)

Q2: What cultural group do you belong to now? Are the five defining characteristics of this group the same as those of the previous one?

How do these cultural practices affect the way you perceive the children and families you work with? You may want to discuss this with colleagues.

Participation and empowerment
More recently, people have become aware that the balance of power between children and adults, service users and service providers also needs to be attended to so that therapeutic relationships are just (fair), empowering and based on partnership. Another name for this is participation [191, 202].

Read the Young Minds document on participation, which is available on the YoungMinds website (http://www.youngminds.org.uk) and applies to the UK as a whole; and the Headsup Scotland document (http://www.headsupscotland.com), which is specifically Scottish.

Children and young people themselves have made it abundantly clear that they want to participate, particularly in decisions of current relevance to their lives like their education, leisure and health care; but if their views are ignored, they become disillusioned [203].
Some children and young people are not used to being asked their opinions; some are particularly vulnerable. Participation includes supporting them to find ways of exploring and expressing their opinions.

Empowering young people, whose developmental tasks include distancing themselves from adults and their plans, requires some discretion and subtlety and is different from empowering children. Young people sometimes need to disagree with adults in order to test their autonomy.

Have you had experience of empowering young people? What would be a good way to manage it? Discuss it with colleagues and your facilitator.

However, there are other important considerations in participation activities with children and young people, apart from sharing power. Decisions about the young people’s own treatment must take into account the life-threatening character of some of these decisions and their short and long-term consequences, as well as the age, level of disability and mental capacity of each particular young person. But if a decision has to be made that a young person does not agree with, the reasons for this must be fully explained.

Only then, when participation activities have been carefully thought through, can children and young people be engaged with genuine honesty. This contrasts with making blanket promises of participation that, because of circumstances, cannot be kept and lead young people to be disillusioned [204].

Can you think of any issues that hinder participation with the children and/or young people you work with? How might they be overcome?

6.10.2 A reflective model

Reflection is a process by which you describe, think about, analyse and critique something you have learnt or experienced [205, 206]. You can reflect by yourself by thinking through a particular incident or piece of work or you can go through the process with others. The aim is to understand it better, assimilate it, evaluate it and sometimes make decisions. In the short-term, it is easier not to be reflective because it appears to save time, but in the longer-term it damages your ability to cope well with complex situations, decisions and relationships and to learn from experience.

Reflection is at the heart of our relationships with children, young people and families — how else could we do justice to the subtlety and depth of the child’s view of the world discussed in Chapter 5? We reflect with them, and we reflect about them. Reflection is also central to clinical supervision and to the assimilation of new learning.

Table 2 gives a schematic representation of parallel core CAMHS activities for which the reflective process is useful, i.e. when planning treatment with young people and families, in clinical supervision and during the process of learning with your facilitator.
Table 2: The reflective process in interaction with clients / clinical supervision / a learning situation [207]

<table>
<thead>
<tr>
<th>Reflective process</th>
<th>Role of the Young Person / Family Supervisee Learner</th>
<th>Role of the Professional Supervisor Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>Of the problem(s) and their background</td>
<td>Of their understanding of the problems</td>
</tr>
<tr>
<td></td>
<td>Of a specific incident or experience</td>
<td>Listening and facilitating</td>
</tr>
<tr>
<td></td>
<td>Of a specific incident or situation</td>
<td>Listening and facilitating</td>
</tr>
<tr>
<td><strong>Thoughts feelings</strong></td>
<td>About the situation</td>
<td>About the situation</td>
</tr>
<tr>
<td></td>
<td>About the incident or experience</td>
<td>About the incident or experience as described by the supervisee</td>
</tr>
<tr>
<td></td>
<td>About the incident or situation</td>
<td>About the incident or situation as described by the learner</td>
</tr>
<tr>
<td><strong>Analysis</strong></td>
<td>Of what has been tried / what could be done</td>
<td>Of what can be offered in the light of understanding and available opportunities</td>
</tr>
<tr>
<td></td>
<td>Of what the incident or experience means to the client and to themselves</td>
<td>Of what the incident or experience means from different angles</td>
</tr>
<tr>
<td></td>
<td>Of what sense can be made of the incident or situation making use of available knowledge</td>
<td>Of how the incident or situation can be related to relevant theory / scientific facts</td>
</tr>
<tr>
<td><strong>Evaluation</strong></td>
<td>Of these possible solutions from their point of view</td>
<td>Of these possible solutions from the service point of view</td>
</tr>
<tr>
<td></td>
<td>Of what was good and bad about the experience</td>
<td>Of what was good and bad about the experience</td>
</tr>
<tr>
<td></td>
<td>Of what was good and bad about the incident or situation, from both an affective and a cognitive perspective</td>
<td>Of what was good and bad about the incident or situation, from both an affective and a cognitive perspective</td>
</tr>
<tr>
<td><strong>Discussion</strong></td>
<td>Of possible solutions</td>
<td>Of possible solutions</td>
</tr>
<tr>
<td></td>
<td>Of what could have been done / be done now</td>
<td>Of what could have been done / be done now</td>
</tr>
<tr>
<td></td>
<td>Of what else could have been done and what can be learnt</td>
<td>Of what else could have been done and what can be learnt</td>
</tr>
<tr>
<td><strong>Decision</strong></td>
<td>A shared decision which may be a compromise between the desirable and the possible</td>
<td>A shared decision which may be a compromise between the desirable and the possible</td>
</tr>
<tr>
<td></td>
<td>Actions to be taken by the supervisee as a result of supervision</td>
<td>Actions to be taken by the supervisor as a result of supervision</td>
</tr>
<tr>
<td></td>
<td>Action to be taken by the learner as a result of the discussion</td>
<td>Action to be taken by the facilitator as a result of the discussion</td>
</tr>
</tbody>
</table>
Using reflection with children, young people and their families
During your assessment, you have learnt a lot about a particular young person and their family. It has led you to a professional understanding of how the problems have come about and what therapeutic interventions might be helpful. Now you and your team might be tempted to impose this on the family as a professional recommendation. But you have also learnt to relate to this young person and their family. You have acquired an affective knowledge of them — an empathic understanding has taken place in your relationship with them. They too are experts about this problem: they have experienced it for months, perhaps years. So both groups (the family and the professionals) have complementary expertise which can be used, reflectively, to plan the next move: the therapeutic intervention. Sharing your professional knowledge with the young person/family and demystifying it, making it accessible, will help in the process.

Using reflection in clinical supervision
The goals of reflective clinical supervision are support, personal development and skills enhancement of less experienced workers by more experienced ones. Clinical supervision can also be a way in which managers check out that their staff use work time productively [208]. While there is place for this, it is not what is meant here.

Each of us comes to this kind of work with our own past experience of life, our emotional wounds and our mental health problems. While we want to help the children and young people in our care, some of their problems resonate with us in personal ways. We need to notice the connections with our own childhood or adolescence, with our own experience of parenting, as children or as parents. Clinical supervision, when it is based on a reflective model, encourages this to take place in a safe context and allows workers to experience the containment they routinely offer to children and young people. Without clinical supervision, defence mechanisms can be over-used to give protection from anxiety and mental pain [125]. As a result of clinical supervision, our work should be more effective.

The professional experience in health and social care can also be difficult because it is one of uncertainty, complexity and instability. Clinical situations change frequently and quickly, and they are often unclear. This is confusing for everyone, but perhaps particularly for you at this stage in a new service. Yet, because our clients are all different, and each is in a unique and complex situation, we have to live with the confusion — there is no short cut either to clarity or to certainty. While reflecting on our own can ease the difficulty a bit, reflection with a facilitator or senior colleague has the advantage of adding other viewpoints and challenging blind spots we are likely to have about ourselves (see the Johari Window below).

Table 3: the Johari Window [209]

<table>
<thead>
<tr>
<th>Known to self</th>
<th>Not known to self</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Known to others</strong></td>
<td><strong>Increased via Clinical Supervision</strong></td>
</tr>
<tr>
<td><strong>Known to self</strong></td>
<td><strong>Open Self</strong></td>
</tr>
<tr>
<td><strong>Not known to others</strong></td>
<td><strong>Hidden Self Revealed and explored via trust and confidence in clinical supervision</strong></td>
</tr>
</tbody>
</table>

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Practitioners working with children and young people whose psychosocial circumstances may include neglect and abuse, trauma and other past or present distress can find it painful and be traumatised by the work themselves over a period of time. It is important to find fruitful ways of looking after yourself.

Q1: How do you use your time off?

Q2: What are your favourite ways of renewing your energy and assimilating the difficult life experiences you encounter at work?

Q3: Is this enough?

Using reflection in a learning situation
Reflective conversations can also support the learning process. It is tempting for inexperienced learners to look for techniques as a defence against the insecurity of not knowing. A facilitator or supervisor can help the learner access scientific knowledge and useful theories while being aware that learning also takes place by examining everyday experiences.

The regular use of reflection will help you develop a process of meta-cognitive monitoring (see Section 6.6.1) in relation to your work and your own learning, something like an internal supervisor.

Where do you fit in?
Most of us have instinctive preferences regarding the available ways of understanding mental health problems. One model may seem more appropriate – or less threatening – to our own mental functioning.

Which of the models discussed in Sections 6.4 to 6.8 do you feel more comfortable with? Why do you think this is?

Learning styles
Each of us has preferred ways of learning: some are more intuitive, some more pragmatic, some enjoy abstract concepts and theory, some value a clear, step-by-step approach. Depending on your own preferred way of learning, the models discussed in Section 6.4 to 6.8 will have a different appeal to you.

Complete a learning style questionnaire (a well respected one is the Honey and Mumford (1986) which is available on the web at www.peterhoney.com for a small fee) [210]. There are others on the web and in psychology textbooks.
Now, discuss the results with colleagues and compare your learning styles. Also compare your preferences regarding the social / systemic / psychodynamic / cognitive behavioural / biological models. Make notes in your portfolio.

The hope is, of course, that by better understanding our subtly discriminative processes, we will become more open-minded about aspects of our work that we are less spontaneously at ease with. Our goal is to be familiar with all the possible ways in which a child, young person or family can be helped, and to select the most helpful ones — not the ones we like best.

**Conclusion to Section 6.10**

In this section, we have reviewed the importance of the therapeutic relationship to ensure that children and young people remain at the centre of the assessment and the treatment planning, and fully involved in them. A reflective way of working can help you integrate the needs of children and young people and your own needs for learning and mental wellbeing.

**Recommended reading**

**Family / systemic ways of thinking about mental health**


**Attachment**

**Psychodynamics**

**Cognitive Behavioural Therapy**
*Burns, D (1999)* *The Feeling Good Handbook* New York: Plume

**Neuroanatomy, physiology and genetics**

**Assessment and formulation**
Reflection
Chapter 7: Risk taking with children and young people

7.1 Introduction

In this chapter we will be looking at risk taking with children and young people, and relating it to specific problems where taking risks is important. The chapter will start with a look at risk in general and examine the concept of risk-taking in today's society. You will be expected to explore your own attitudes to risk taking and look at areas where it is easier and areas where it is more difficult for you.

The chapter will discuss issues around young people at risk to themselves, at risk from others, and at risk to others. The preceding chapters have emphasised the importance of embracing uncertainty rather than rushing into some definite belief, idea or precipitate action that is not really justified. Even the theories and working models introduced in the chapters are just that, i.e. none represent absolute truths. Reflective practice involves tolerating uncertainty, and the accompanying anxiety, rather than reacting to the anxiety [211].

This is nowhere more important than when dealing with situations that seem to involve risk, particularly because of concern that young people or parents may complain and litigation may result. Self-criticism by the practitioner in such circumstances is almost certain. A careful evaluation of risk is always important, but ideas about 'right' or 'wrong' risk-taking involves moral language, not objective measurement. The high-risk behaviour of some adolescents, for example recreational drug use, involves language derived from how adults construct their ideas about what they should do [212].

Over the last ten years there has been a drive to obtain a common view of risk which health professionals and the general public can share, whilst at the same time trying within health service units to develop an institutional culture where errors can be acknowledged so that learning from these is more possible. Yet the most significant contribution to better understanding risk probably arises from outside medicine, from social anthropology - where Mary Douglas and colleagues have argued that risk is socially constructed [213].

One person's idea of risk may not be another's, and views about what society considers risky change over time. Within a single CAMHS team very different ideas about risk may be present, and — if a general observation can be risked! — inexperienced staff are prone to take fewer risks than more experienced colleagues. This chapter will present a number of different scenarios for you to explore, and reflect on yourself and with your colleagues — you will be encouraged to think about how you might proceed in each scenario.
7.2 Learning outcomes

This chapter should help you to:

1. be able to reflect on the impact of your own view of risk when working with children and young people.
2. identify factors which place children and young people at risk to self, to others and from others.
3. develop strategies and interventions to help children and young people manage feelings and behaviour which places them at risk.
4. develop an understanding of the principles of child protection.

As a society we are generally concerned about risk, particularly where the risk relates to children and young people. It could even be argued that we are currently more averse to taking risks than ever before. Whether not taking risks is harmful to children is open to debate and, hopefully, by studying this chapter you will be able to consider this and reach your own conclusion.

The childhood most of us who are over 30 years old experienced starkly contrasts to the one most children experience now. When we were children, most of us were able to leave home and return later in the day without creating much anxiety in those around us. Has this experience changed for children? If it has, it is important to understand why. Understanding how society and we personally construct and view risk is important in understanding how we construct and take risks in practice.

In this chapter you are going to be asked to reflect on a number of tasks. Being able to reflect on your practice will be an important part of your learning. If you are unfamiliar with reflection you may wish to read the section on reflection in Section 6.10.2 again before starting the following activities [205, 214].

To help you explore some issues around risk, answer the following questions and make notes in your portfolio about the issues. You can then discuss your findings with your facilitator at your next meeting.
Q1: As a society are we less willing to take risks with children and young people?

Q2: If you think the answer is yes what do you think are the reasons?

Q3: If the answer is no – when do you think as a society we were equally risk-avoidant and why?

Q4: What areas in your daily life do you find it difficult to take risks with and what are the areas you find it easier to take a risk?

Take a few moments to reflect on your answers and examine your attitude to risk taking.

When people think about risk and young people they usually come up with a couple of areas:

- That there is a real fear of children being abducted or hurt by adults.
- That the streets aren’t as safe as they used to be.

As far as the first issue is concerned, child murders have remained relatively stable in Scotland. In the last 10 years, of the 96 children under 16 years of age who were murdered in Scotland, 48% were killed by one of their parents. Of the 27 children under the age of one killed in the last 10 years, all were killed by one of their parents.

Further statistics can be found at: http://www.scotland.gov.uk/Publications/2005/12/13133031/30329.

The perception is that the streets aren’t as safe as they were – but that is mainly down to the motor-car and binge-drinking. There is clearly something we can do to address the problem of road safety for children, and there are issues which need to be addressed about alcohol misuse.

So why are we talking about risk in general when this is a training package concerning mental health? Well, quite simply, the context in which we live is bound to have an effect on how we think of and work with issues such as risk. To put it simply, if we don’t take risks in our daily lives, then how can we take risks at work? There are pressures in society to conform and not to take risks, and as professionals we have to consider the relevance of these pressures and come to a decision that is in the best interests of the child. This is inevitably going to involve taking risks to help the child to grow.

There are, of course, different kinds of risk — calculated risk and risks that aren’t thought through. Hopefully, this chapter will help you decide when to take a risk and when to be more cautious.
In our day-to-day lives at work we face many risks - some we will take, and others we will avoid. Think about the last week at work. Have you had to make a decision which involved a child and risk? Make notes in your portfolio. If you are having difficulty thinking of an example from the last week, try and think of other times when you have had to make decisions about risk.

Take the example you have noted and explore it in more detail using the following checklist (if you have more than one example, choose one you would like to think about). You might also want to talk about this with your facilitator or colleague. In any event, make notes in your portfolio and use them as a focus for discussion at your next meeting with your facilitator.

- Looking back do you feel you made the right decision for this child?
- What have been the positive and negative consequences of this decision?
- How did you go about making the decision? Describe the process.
- Did you consult with your colleagues. Why or why not? Would you do the same again?
- What were your major concerns about taking a risk?
- Are there on-going concerns about the child - if so what plans do you have for dealing with these concerns?

Risk assessment has become an almost day-to-day part of working in CAMH services [215-217]. The very nature of the work means there is an element of risk-taking threaded throughout. How we assess and manage risk will be very different for different individuals, and will be influenced by factors such as training, profession, work environment, and personal predisposition to risk. Having looked at risk with children and young people in general, we are now going to examine three categories of risk where children and young people are: at risk to themselves, at risk from others, and at risk to others.

### 7.3 Young people at risk to themselves

Risk is not just related to mental health — children and young people are particularly at risk in their developing sexuality. Young people can take actions in their sexual behaviour which puts them in risky situations. The avoidance of risk, such as not wanting to risk being seen as uninformed about condom use, can also put a young person at risk [218]. Discussions of young people and sex often problematise young people's behaviour, seeing sex as risky and something to be avoided. There are of course risks associated with embarking on sexual experiences: risk to reputation; risk of pregnancy; risk of infections; risk to safety; and risk to young people's emotions [219, 220].
Young people need information so that they can make informed choices about their sexual behaviour. In Scotland sex and relationships education (SRE) starts in primary school which is part of an approach to help children make healthy choices. There is some evidence that SRE programmes are associated with delay in first intercourse and with increased contraceptive use, and no evidence that such programmes result in a rise in pregnancy rates or an increase in sexual activity [221].

Young people also take risks with substances such as alcohol and drugs. The factors in the home which make young people at risk to substance misuse include parental substance use, poor discipline, family disruption, conflict and poor supervision. The older the child is when they start taking drugs, the less likely they are to develop problems. Stress, depression and anxiety predispose young people to substance use, as does aggression and ADHD. The factors which protect against the development of drug misuse are high self-esteem, high socio-economic class, parental disapproval of drug use, a cohesive family and close attachments. Being involved in leisure and religion and achieving in education are also protective factors [222].

The role of the peer group is very important — if your peers take drugs, you are much more likely to be taking drugs than if they aren’t. There are obvious risks to health from substance misuse, some of which are physical. There is also a strong link between substance misuse and suicide [223].

Working on children and young people’s self esteem can make them resilient to drug use, and encouraging the uptake of leisure activities and improving their educational experience are factors which make young people less likely to become involved in drug use. There has been some success with school-based prevention programmes such as life skills training [224, 225], which were reported as substantially lower levels of smoking, use of alcohol, and the use of illicit drugs.

Think about the areas where children and young people may be at risk to themselves and make a list in your portfolio. How many of the factors in the list do you think are contained within the domain of mental health?

**Recommended reading**

Burtney, E and Duffy, M (2004) *Young People and Sexual Health: individual, social and policy contexts* Basingstoke: Palgrave Macmillan

While children and young people can be at risk to themselves whether or not they have a mental health problem, the distress brought about by having a mental health problem can make young people at risk to themselves in particular ways. There are mental health problems which may make children and young people more at risk than others. Discuss with your facilitator and make notes in your portfolio of the kinds of mental health problem a child or young person may have that makes them more vulnerable to risk.

7.3.1 Risk taking and self-harm
Self-harm in children and young people is an area which adults are becoming particularly concerned about. Self-harm is being spoken about and reported more openly in the media including children’s television. Children who are self-harming can invoke feelings of great concern and helplessness in those around them. In this section we are going to be looking at the issue of self-harm and how this relates to risk, but first it is important for you to acknowledge what you understand by self-harm.

When you think of self-harm what are you thinking of? Make notes in your portfolio. You will have the opportunity later to compare your thoughts with other people’s, for now, just concentrate on your own thoughts. Are there acts of self-harm you find more difficult to tolerate or deal with, what are these and why do you think these affect you differently? Again make notes in your portfolio and discuss them with your facilitator the next time you meet.

When working with children and young people, it is important to uncover any blind spots we may have — they usually get in the way at some point if we don’t deal with them!

It is worth noting here that this self-reflection is an important part of our work — no-one is perfect, so uncovering what makes us tick can be helpful in understanding our reactions to and feelings about children and young people. Thinking we are always right and unaffected by the distress children and young people are feeling could become a block to learning.

Risk factors and self-harm

Kenneth’s life illustrates a number of examples where people involved with him had to make decisions about risk. Refer to the start of Kenneth’s story on p11 – here the SHO is faced with the dilemma of how to respond to Kenneth’s self-harm and what to advise hostel staff. In your portfolio, make brief notes of the decision she reached and what you think informed her decision.
Now separately discuss with your facilitator and another colleague how they would have assessed Kenneth — you might want to bear in mind issues such as whether they would use a formalised assessment, whether they have discussed it with other colleagues, what risk factors would they have taken account of, and what plan would they have put in place? What are the differences in their approaches? Make notes of the strengths and weaknesses of each approach — which one do you prefer? If the people you talk with use the same method, seek out a member of staff who has a different approach. If your colleagues all use the same approach, contact a service from a different locality and ask if you can speak to someone about how they assess risk and self-harm.

You may want to contact someone out with your area whatever your findings are — developing networks will become a very important aspect of your work. You will find there is more than one way of working with children and young people, and discussing different approaches will enrich and enhance your practice. Make notes of your findings in your portfolio.

There are a number of factors that put Kenneth at risk of self-harm, and it is important to know what these are. Reported self-harm is on the increase and is causing concern amongst the general public and mental health professionals. Factors that make a young person more likely to self harm are as follows:

1. Young people in prison are a particularly vulnerable group, especially those on remand, which may suggest that isolation, hopelessness and alienation could play a part in the development of self-harm as a coping strategy. Most young people, however, have harmed themselves before they enter prison.
2. Young people from rural areas are more likely to harm themselves than those in urban areas, and it has been suggested that isolation may play a role here.
3. Young Asian women in Britain are another group vulnerable to self-harm. It is thought this may be due to a clash of cultures experienced by these young women.
4. Because of the isolation and lack of opportunity available to them to talk about their feelings, lesbian, gay, bisexual and transgender young people are also a vulnerable group.
5. Children and young people with learning disabilities are vulnerable to self harm.
6. Care leavers are the final group, and are more likely than young people from the general population to have attained poor educational standards and to end up in prison.

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3 You can find contact numbers for CAMHS services throughout Scotland in Appendix 3 of the document.
What other factors do you think played a part in Kenneth’s self-harm? To do this you may want to go through Kenneth’s history again, starting with his birth and try to identify factors which make him vulnerable to self-harm. Make notes in your portfolio.

Discuss your findings with your facilitator or a more experienced colleague, did they have a different viewpoint or understanding of what made Kenneth vulnerable? There is a National Inquiry into self-harm which it is essential you learn about. The National Self-Harm Inquiry is looking at a number of factors such as reasons why young people self-harm and effective interventions. You can also compare your thoughts about what constitutes self-harm with those outlined by the inquiry. The Inquiry’s website can be found at: http://www.selfharmuk.org/

**Recommended reading**


These guidelines can be accessed on the internet at: http://www.nice.org.uk/download.aspx?o=cg016niceguideline


**Managing self-harm**

We are discovering more and more about self-harm and hopefully we are beginning to change our perceptions and attitudes. Rather than people seeing self-harm as a display of attention-seeking, it is being seen as a way young people manage and express their internal distress.
Take a few minutes to think about your attitude to people who self-harm. If you have known a child or young person who has self-harmed, how did you feel about their self-harm? Make notes in your portfolio and discuss your feelings with your facilitator when you meet next, it is important to be honest with yourself about your feelings. Harbouring negative or helpless feelings may get in the way of helping another young person who self-harms.

Helping children and young people manage their self-harm can be a difficult and sometimes daunting task — it can raise issues in those trying to help, such as wanting to protect the child or young person, or feelings of helplessness. An important thing to remember is that children and young people have many different reasons for self-harming, and there are equally many different ways a child or young person can be helped.

Make notes in your portfolio of all the ways you think a child or young person might be helped to manage their self-harm. You should aim to build up a resource file where you can record a variety of methods. You can add to this file through discussions with colleagues, young people and through your research.

Helping parents and carers manage risk
Having or looking after a child who self-harms, can be distressing for parents and carers. There is some evidence that parents of children who self-harm are unaware that this is happening. A national survey of the mental health of children examined parents’ and children’s reports of self-harm and suicidal intent amongst children. Parents reported prevalence rates of 0.9% for five to seven year-olds, 1.7% for eight to ten year-olds (there is no comparable data from children’s accounts between these ages in the study). Parents reported prevalence rates of 1.6% for 11-12 year olds and 2.5% for 13-15 year olds, while children reported 4.6 and 6.6% respectively for the same ages. This shows quite a difference between what parents think is happening and how children themselves perceive the problem. The report can be found at:

At one level, this research might indicate that parents aren’t that anxious about their child self-harming, or that parents find it difficult or don’t want to think that their child is self-harming. It also challenges the notion that young people are just attention-seeking when they self-harm — attention-seeking and hiding things don’t really go together. Whatever the reason for parents not knowing, when they do know it usually causes them distress and they will often seek help. CAMH services have a dual role in managing the anxiety that self-harm raises — as a service you have to help parents and carers take risks (e.g. not constantly supervising the child or young person) at the same time as providing containment for the child or young person. CAMHS also have a role in managing the anxiety of primary care workers who come into contact with children and young people who self-harm.
Think about how you would develop interventions to help parents or teachers manage their concerns about children or young people who are self-harming. Make notes in your portfolio on how you would structure the intervention. Are there any resources you can draw on to help you, such as colleagues or research findings?

One of the more controversial strategies to help young people manage their self-harm is to allow them to harm themselves in a safe environment. At the time of writing, there are a number of organisations which follow this strategy. 42nd Street in Manchester have allowed young people to self-harm on their premises for a number of years, and North Staffordshire Health Authority are running a pilot study on the effectiveness of a similar approach [228].

Such strategies probably run counter to most people’s intuition – what are your feelings about using a similar approach? What would the benefits and risks be? Make notes in your portfolio and discuss them with your facilitator.

Young people who self-harm can be seen as being at risk to themselves, although this may not always be the case. In Kenneth’s story his self-harm can be seen as an adaptive coping mechanism — it helps him to manage and is not as concerning to him as it is to those around him.

7.3.2 Young people and suicide

Self-harm is not the only area where there is concern about young people being at risk to themselves. Suicide is another area that causes where a great deal of disquiet [229].

Recommended reading


DiAugelli, A R et al (2005) Predicting the Suicide attempts of Lesbian, Gay and Bisexual Youth Suicide and Life-threatening Behaviour 36, 646-660

Suicide in Scotland is much higher — nearly twice — than it is in England. There may be particular reasons for this, such as the isolation of some communities in Scotland, or the difficulties Scottish young men have in forming a positive adult male identity.

It may be helpful to discuss with colleagues why they think there are such differences in the rates of suicide between England and Scotland. A good starting point for looking at the issue of suicide in children and young people is the Scottish Executive Choose Life Strategy, which can be accessed at: http://www.scotland.gov.uk/library5/health/clss-00.asp

On this website is a graph of suicide rates from different countries around the world. There are significant differences between countries, so something is happening culturally, environmentally or geographically. There will not be a simple answer as to why these differences are occurring. The answer is likely to be complex and be a result of a number of interrelated factors.

Can you think of an explanation as to why there are such different suicide rates between countries? Show the graph to your facilitator and discuss the different reasons you both think these differences occur.

The suicide rate amongst young people and young adults rose in the 1990’s and early 2000’s [230] and this trend particularly applied to young men. The Choose Life campaign has an aim of reducing suicide by 20% by 2013 amongst the general population, although it is too early to say what the actual effect of the campaign is. Each area in Scotland has its own Choose Life local action plan to prevent suicide, and you should familiarise yourself with the one for your area. An example of a local plan (for North Lanarkshire) can be found at: http://www.northlan.gov.uk/your+council/policies+strategies+and+plans/jhip/choose+life+action+plan.html
Half the young people who go on to commit suicide will have had contact with the health service in the previous week, so there is a window of opportunity that we need to recognise as professionals. Helping the young person delay the suicidal act is very important. Young people can be very impulsive, so helping them think rather than act is essential [231].

It is important therefore to understand the risks associated with suicide. We will look at risk factors later, but for now you should make notes in your portfolio about what you think the risks for suicide in children and young people are and the mental health problems which are most likely to contribute to young people attempting suicide?

We are going to look at a number of different scenarios about suicide in children and young people with mental health problems. You will be asked to look at the risks for suicide and the protective factors which may make them resilient to suicide and what plans you would make for the child or young person. The first scenario is about the risk of suicide in a young person who has a low mood following a period of grief. When working through the scenario think about the factors which make her more vulnerable and the factors which you think might help her be resilient to suicide. As mentioned earlier resilience is discussed in Chapter 4, you may wish to familiarise yourself with the concept again before reading the following scenario.

**Amy**

Amy is a 15 year-old girl who is having problems at school. Normally she is outgoing and well liked by her peers, but recently she has become withdrawn and has stopped mixing with her friends.

Her withdrawal seems to be associated with her falling out with a group of close friends. She started going out with a boy, which caused some jealousy, and on splitting up with her boyfriend her previous group of friends wanted nothing to do with her. She has been bullied by this group and has been found crying by teachers on a number of occasions.

Her father, who suffered from schizophrenia, committed suicide three years ago. Amy went through a period of intense grief but seems to have recovered. Her mother is concerned about her and is very supportive; she has been in regular contact with the school to talk about her concerns. Amy was referred for counselling, has been seeing a counsellor, and is speaking quite openly about her feelings. Recently she has been talking about not wanting to go on, and that life isn't worth living. The counsellor has asked you, as a primary mental health worker, for a consultation.[19]
Q1: What are the risk factors for suicide in Amy’s story?

Q2: What resilience or protective factors does Amy have?

Q3: What advice would you offer the counsellor?

In the following scenario you are being asked to consider the risk factors in a young boy who may have Asperger’s Syndrome [232-234]. Would having Asperger’s Syndrome make him more at risk of suicide? You might also want to consider how you would help Jack communicate his distress.

**Jack**

Jack is a nine year-old boy who has been referred to your outpatient clinic. He has been off school for a month and, despite concerted efforts by parents and school, refuses to go back. He says the rest of the children in his class are hurtful to him and don’t like him.

He has always had some difficulty making friends and his nursery was quite concerned about him. He had a number of developmental delays, he didn’t start to walk until he was nearly three years old, and he had to be taught to feed himself at age four in nursery.

There have been concerns that he has Asperger’s syndrome, although this has not been confirmed. He has a great interest in trains and has a large collection of books on trains. He also spends a lot of time on the Internet looking at images of trains.

He has been referred partly because of his school refusal, but also because recently he has said he wants to die because he is so different from everyone else. His mother and father are supportive. Dad has some obsessional traits and shares Jack’s love of trains.

Q1: What are the risk factors for suicide in Jack’s story?

Q2: What resilience or protective factors does Jack have?

Q3: What would be your plan for helping Jack?

In this next scenario you are being asked to consider the risks factors for suicide associated with anorexia nervosa. You are also being asked to consider the risks and a strategy for dealing with such risks for someone who is recovering from depression.
Claire
Claire is a 17-year-old girl with a history of anorexia nervosa [235] [236-239]. She has been an in-patient for the last five months and has made some progress in terms of her weight. She has two brothers and two sisters all of whom are living at home.

She has had anorexia [240] for a number of years and usually responds to treatment which has previously involved seeing a cognitive behavioural therapist [241]. The time gap between recovery and relapse of her anorexia has shortened.

Life at home has been quite stressful — one of her younger sisters has started to develop similar eating habits. Meal times are very stressed. Dad tends to avoid being there, using work as a reason (he is a successful accountant who has largely left the care of the children to his wife). Mum is very anxious herself, as she had a period of restricting her food intake when she was younger. She managed to deal with this without it ever leading to anorexia.

What has complicated Claire’s treatment this time is that she has been severely depressed, for which she initially received counselling with little effect. At the time of her admission to the unit she said she wanted to die, which she continued to voice over the next few weeks. Since being admitted to the unit she has been commenced on Fluoxetine in conjunction with Cognitive Behaviour Therapy [242]. She is currently receiving 40mg Fluoxetine a day. Initially her depression led her to feeling quite hopeless — she thought her life was worthless, that she was a burden to everyone, and that the family would be better off without her. She has responded quite well to the Fluoxetine and CBT, her mood has improved, she has put on two kilos in the last three weeks, and her mood seems to be lifting.

Initially she had features of psychomotor retardation (a slowing of mental and motor activity) which gradually improved as well. She wants to have an overnight pass for the weekend, as it is her sister’s birthday. She has been on one previous overnight pass where she struggled to eat, but managed to do so with help from her mother.

Q1: What are the risk factors for suicide in Claire’s story?

Q2: What resilience or protective factors does Claire have?

Q3: Are there risks in Claire having an overnight pass?

Q4: How would you minimise such risks?

7.4 Young people at risk from others
Children, by the very nature of their developmental stage, are vulnerable to adults. Children need protection, and parents/carers obviously play a central role in this. Experiencing a mental health problem can make young people more at risk. Emotional, physical and sexual abuse can contribute to mental health problems, and protecting children from such abuse can help prevent mental health problems.
What follows can only be a brief introduction to the subject, and it is imperative that staff working with children access further training to develop knowledge and skills in this area. You must familiarise yourself with your local child protection guidelines as that has useful information for you. An example of a local child protection guideline for social work can be found at: http://www.highland.gov.uk/swintra/social_work_services/children/child_protection/cp_policy_guide2.pdf

Children can be at risk from adults and also from other children where bullying is a particularly difficult issue for young people to cope with. We will be looking at bullying later in the section of young people who are at risk to others, but of course it could equally fit into this current section on young people who are at risk from others.

In this section we are going to be looking at a number of different child protection scenarios and how you might tackle them. We have tried to contextualise these scenarios so you can choose one or two which fit your current circumstances. We will finish this section on risk by looking at the issue of emotional abuse, which is an often-overlooked aspect of child protection. The recommended reading for this section is at the end of the section on emotional abuse.

The first scenario in this section illustrates a problem where there is concern about a child whose behaviour has changed. You are asked to reflect on how you would proceed when there is little concrete evidence that this is a child protection issue.

Providing consultation to a school

Habib

You are a primary mental health worker with responsibility for providing consultation to a primary school. You meet with the teachers meet to discuss children they are concerned about. This week they talk about Habib; he is a nine-year-old boy living at home. When he started school, Habib had problems settling in because he was quite shy. The school put in a lot of effort; he overcame his shyness and has a small group of friends. The teachers report that he has gradually become withdrawn and tearful, and has started to wet himself in school. The teachers have noticed bruising around his wrists, which Habib says was the result of fighting. They spoke to his parents but they can’t explain his change in behaviour. Habib isn’t talking to anybody about his change in behaviour and offers no explanation.

Q1: What are the child protection issues in this scenario?

Q2: What advice would you offer the teachers?

Q3: What would you do yourself?

Make notes in your portfolio and discuss your findings with your facilitator.
The next scenario raises a number of issues including parental substance misuse [243, 244] and potential neglect. You are presented with information which is worrying but unconfirmed, and are being asked if you can act on the information you have. If you can act, how would you proceed? Do you need more information and if so how would you go about finding it?

Hayley
At one of your regular meetings with the group of teachers, one of them speaks about Hayley who is 12 years old and has just started secondary school. She had been known to her teachers prior to starting and had been part of a transition group from the primary school. She has a very flat affect, and the teachers are wondering if she is depressed. She does not mix with the other children, and is often seen standing by herself in the playground. One of the teachers wondered about counselling and met with Hayley’s parents to discuss this. The teacher described them as dismayed at the thought of Hayley getting counselling and very much against it. There have been rumours that Hayley’s parents misuse drugs and concerns about the care they provide for her. Hayley said to a teacher that she often has to make her own meals and sometimes there isn’t food in the house and she has resorted to stealing from local shops.

Q1: What are the child protection issues in this scenario?
Q2: What advice would you offer the teachers?
Q3: What would you do yourself?

Make notes in your portfolio and discuss your findings with your facilitator.

The next scenario involves a girl who you are asked to consider if she is being bullied. There are also cultural and communication issues which you should consider.

Bintu
At your regular meeting with the teachers they discuss Bintu a 14 year-old girl whose family fled Liberia and are refugees in Scotland. She has only been in Scotland for over a year, but her English is good. She has been in education since arriving in Scotland but has moved around the country, only settling in your area last month. She started her current school three weeks ago and has been teased and called names by a group of other girls in the playground because of her name and the way she dresses. Bintu is clearly upset by this but doesn’t seem to be able to respond. The school has had very few asylum seekers or refugees before and they aren’t sure what to do so they seek your advice.
Q1: What are the child protection issues in this scenario?

Q2: What advice would you offer the teachers?

Q3: What would you do yourself?

Make notes in your portfolio and discuss your findings with your facilitator.

**Child protection in the out-patient setting**

In this scenario there is clear evidence of abuse, and you have to decide whether you think this is a matter to be taken further and invoke child protection procedures or it is a matter which has to be worked on therapeutically.

**Callum**

You have an appointment to see a family you have seen on three previous occasions. Callum is the boy who has been referred. He is 16 years old and has been self-harming by cutting for a few months; he also runs away from home.

You appear to have engaged his parents, who both attend and are very concerned about Callum. Both parents are struggling to know how to help Callum, but are keen to take advice. His parents have arrived at the meeting without Callum, as he didn’t return home last night. You decide to meet with the parents to talk things over when the receptionist says that Callum has arrived. You go out to meet him, and are quickly followed by his father who shouts at Callum saying that he has caused his mother to have a sleepless night and that he is selfish. Dad strikes Callum across the face with the flat of his hand. You take them into the interview room, and Callum says he deserved to be hit by his dad and doesn’t want anything to happen.

Q1: What are the child protection issues in this scenario?

Q2: What would you do yourself?

Make notes in your portfolio and discuss your findings with your facilitator.

In the next scenario you are being asked to interpret an eight year-old child’s drawing and, in conjunction with examining her behaviour, to think about whether this raises concerns about child protection.
**Emma**

You are seeing an eight year-old girl Emma and her mother as an out-patient. Emma is having difficulties at school and was referred because her teachers are worried about her behaviour in school. Emma is wary of her teachers and avoids eye contact with them. She gets on alright with her classmates but on occasions she has been talking inappropriately about sexual matters.

You have seen her a couple of times with her mum. Her step-dad refuses to come to the meetings. Although she is wary, you feel you are getting somewhere with her. You have started using art materials with her: she has drawn buildings which look like they are on fire with children trapped inside while a woman stands watching. This week she has drawn what appears to be a picture of what looks like a penis.

Q1: What are the child protection issues in this scenario?

Q2: What would you do yourself?

Make notes in your portfolio and discuss your findings with your facilitator.

**In-patient unit scenarios**

The first scenario in this sub-section asks you to think about working with colleagues and the issue of appropriate professional boundaries. You are being asked to consider whether the member of staff is being helpful or is getting his boundaries muddled. The scenario touches on the problem of how to handle staff conflict and difference of opinion.

**Bob**

Bob is an experienced member of staff who has developed a close relationship with Alisha, a 14 year-old girl who has been admitted to the unit for treatment of her depression. She has been receiving Interpersonal Therapy [245, 246] and been treated with Fluoxetine. She recently made a serious suicide attempt. Alisha has been in the unit for a month now, her depression is lifting and, while she did not initially speak, she is starting to confide in Bob. Alisha seeks out Bob when he comes to work and is spending long periods of time speaking with him, sometimes in the communal area at other times in her room. You are a new member of the team and are starting to feel uncomfortable. You share your concerns with another member of staff who says not to worry; Bob is very good at helping people talk through their depression.
Q1: What are the child protection issues in this scenario?

Q2: What would you do yourself?

Q3: How would you manage the different opinions you and the other member of staff have?

Make notes in your portfolio and discuss your findings with your facilitator.

This next scenario is about how to react when someone discloses a child protection issue to you and then withdraws it. It also asks you to think about how you would care for someone who has harmed themselves.

**Anne**

You are a staff nurse in an in-patient unit working with Anne a 15 year-old girl who was admitted following an acute episode of psychosis. She was suspicious when admitted and didn’t want to talk to anyone. She was hearing voices commanding her to stand in traffic. Anne was admitted as an emergency after being found by the police standing in the road. She was frightened by the experience and was suspicious of the police. She found settling into the unit very difficult. She cuts herself on her arms and staff are concerned about her. She has been treated with Olanzapine [247] 15mg a day and has responded relatively well. She is also receiving Cognitive Therapy [248, 249] from an occupational therapist to help her manage her symptoms. There have been periods where she refused to take her medication because she worries she will put on weight and is concerned about her appearance [250, 251].

She has spent weekends at home since her recovery. Her parents are separated so she spends one weekend with her mother the next with her father. You have been on duty when she has returned from home and have noticed that she appears more distressed when coming back from her father’s. This weekend she is with her father again. On her return to the unit she appeared withdrawn at first, and when her father leaves she becomes very distressed. She speaks with you about being frightened of her father and says she doesn’t want to stay with him. She immediately withdraws this saying that she didn’t mean to say she didn’t want to stay with him. She leaves and goes to her room, and when you go to speak to her a few minutes later she has cut herself quite deeply on both arms with a razor blade.

Q1: What are the child protection issues in this scenario?

Q2: What would you do yourself?
Q3: How would you manage Anne’s self-harm? Would you ask her to take care of her wounds or would you take care of them yourself?

Make notes in your portfolio and discuss your findings with your facilitator.

**Emotional abuse**

Finally in this section we are going to look at emotional abuse. As we mentioned earlier, emotional abuse has often been considered difficult to identify, and therefore difficult to address. Boulton and Hindle (2000) describe the dilemmas involved in identifying emotional abuse:

“Within our agency many clinicians had been working with families long enough to witness the frequently damaging long-term effects of parents emotionally maltreating their children. We had also become increasingly aware that children who were being emotionally abused were often the most vulnerable, but least likely to attract the attention of the child protection system, with workers feeling impotent in the face of concerns which were difficult to tabulate. Parents presented as either angry with or deeply concerned about their child, but often trawled from one agency to another seeking confirmation that the problem was internal to the child. The professional network in such cases could either be too diffuse, with services delivered in a compartmentalised way in response to specific symptoms, or over-inclusive, with a number of agencies involved simultaneously” [252].

Emotional abuse is an inherent part of all forms of abuse, but can also be identified as a primary concern. This is the one form of abuse that is observable as the interactions tend not to be hidden, but are characteristic of the relationship between the parent and identified child. Glaser states that for the relationship to be identified as emotionally abusive or inappropriate, the interactions must be ‘pervasive, persistent and inflexible’, and suggests six dimensions that provide a framework for observing and thinking about often discordant and difficult-to-understand relationships [253].

1. Persistent negative attitudes towards the child.
2. Promoting insecure attachment.
3. Inappropriate developmental expectations and considerations.
4. Emotional unavailability.
5. Failure to recognise child’s individuality and psychological boundaries.

For more detail on these categories, read Boulton and Hindle from the recommended reading list [252].

💡 Consider a family you are seeing at present in which there are concerns about the interactions between the parent(s) and one of the children. Now record your observations of a family meeting. Do any of your observations fit in with Glaser’s six dimensions of an emotionally abusive or inappropriate relationship? Do you think the interactions observed could be described as ‘pervasive, persistent and inflexible’?
An important point here is what to do if you feel your observations fit into Glaser’s six dimensions. You should consult with your facilitator or a more senior colleague. It may be that your assessment will lead to further clinical work, or it could be that you have to use the child protection procedures.

Recommended reading

John Wiley and Sins: Chichester


7.5 Young people who are harmful to others

Children and young people are more likely to be the victim of violence or sexual abuse than the perpetrator, but there is increasing concern about children and young people being referred to CAMH services for violent or abusive acts toward others [254]. This is a specialised area, and some CAMH services may not accept children or young people with sexual behaviour that is harmful toward others — there are very few such specialist services in Scotland. We may not like to see young people as perpetrators of harmful behaviour, — it sits more comfortably for us to see children and young people as victims of other people’s harm — but this is an important area we cannot ignore. Practitioners need a framework for understanding and assessing risk to others. What we are going to do here is look at some general issues about young people whose behaviour is harmful toward others, look at some scenarios, and then recommend further reading.
There are a number of factors to be considered when assessing risk of harm to others in children and young people. It is important to identify the actual risk factors that are known to predict the kind of harmful behaviour being assessed, such as the number and kind of previous offences.

There are different kinds of factors that predict whether a young person will be aggressive:

1. Stable factors, which are fairly persistent features of the child or young person but which may be amenable to change.
2. Acute factors, such as drug or alcohol intoxication, the mood of the young person, and the kind of social support they have.

Risk factors associated with developing aggression include: being the victim of any kind of abuse, being aggressive previously, exposure to violence in the home, exposure to alcohol or drugs in the womb, genetic factors may also play a part [255]. There are different forms of aggression in children and young people – aggression where the child reacts to an external stimulus, and aggression that is proactive.

1. Reactive aggression is where the young person views other people’s behaviour, in a hostile way, and has an angry response to perceived provocation. These children will usually have a history of being disciplined harshly and will have experienced physical abuse.
2. Proactive aggression is unprovoked, non-impulsive, and directed towards a goal. In the past they will have gained what they wanted as a result of their violence, and the child or young person will usually have been exposed to aggressive role models.

There can, of course, be an overlapping of these two types of aggression, which can present a real challenge to those trying to help.

Bullying is a harmful behaviour that can have an adverse effect on a child’s development [256]. The effects of bullying can be far-reaching and can affect the child’s emotional development and physical well-being. The effects of bullying are being taken into account more, although the prevalence of bullying remains a worry. Bullying is something that should never be trivialised because of the effects it can have on children and young people, leading in the more severe cases to suicide. Bullies themselves are often unhappy people, and the causes of their behaviour can range from low self-esteem to family problems. There are a number of excellent websites are resources for children being bullied, parents and professionals, which are useful resources: [257] [258] [259].

With young people who display sexual behaviour that is harmful towards others there are a number of risk factors to be taken account of [260-262]. The risk factors which make children more at risk of persistent sexually harmful behaviours include a history of frequent physical abuse and childhood neglect. In childhood, these risk factors include: Childhood Conduct Disorder; verbal and physical assaults on peers; aggression towards teachers; severe destructiveness; fire-setting; repeated lying; truancy; running away from home. In adolescence, risk factors include: anti-social behaviour; delinquency; vandalism; aggression; high impulsivity; low social competence; poor social skills; poor assertiveness; peer isolation. These lists reinforce the importance of child protection, as there are a number of risk factors which children and young people could be protected from.
We are now going to look at some scenarios which may help you to think through some of the assessment issues. These scenarios will involve thinking about the potential risk the young person presents, but some will also contain child protection issues.

This first scenario in this section concerns issues about the appropriateness of a boy’s sexual behaviour and how to advise other professionals on helping a young person who may be on the autistic spectrum.

**Graham**

Graham is a 12 year-old boy who has been referred to your service as an out-patient. He has a history of suspected ADHD and is also thought to be on the autistic spectrum. Neither of these has been diagnosed. He has always had difficulty at school and been quite aggressive towards other children, pushing other children over in the playground and getting into fights. There have been concerns expressed by teachers that he was physically abused — there was a social work investigation but nothing was discovered.

Graham lives at home with his parents, an older brother (aged 17) and two younger siblings (aged seven and three). He has been referred to you for an assessment of his ADHD/Autism. However, having read through the referral letter, you notice that there have been a number of occasions where he has been found touching other children in what people have thought might be a sexually inappropriate way. His teachers and parents have spoken to him about this and school are keeping a watchful eye on him. They haven’t involved anyone else because they see this behaviour being largely out of Graham’s control.

Q1: What risk factors for sexually harmful behaviour are present in Graham’s story?

Q2: What are the child protection issues in this example?

Q3: What would you do about these issues?

Q4: Does Graham possibly being on the Autistic Spectrum affect your intervention strategy?

This next scenario is about the use of the Internet [263] to access child pornography. You are asked to consider whether this is a legal or a therapeutic matter or both.

**John**

You are a Primary Mental Health Worker offering consultation to a local secondary school. They have had some problems with a group of boys who have been accessing pornography on the Internet. Their concern is that one of the boys John has been accessing child pornography, and has done so on several occasions. He has e-mailed these images to friends, one of whose mother has complained to the school. You have been asked for your advice.
Q1: What are the risk factors for sexually harmful behaviour present in John’s story?

Q2: What are the child protection issues in this example?

Q3: What would you do about these issues?

Q4: Would you involve the police in this scenario?

This next scenario is about consensual sex. It also raises the issue of confidentiality and whether what is said in an out-patient session should remain confidential to that session.

**Hugh**

You are a clinical psychologist and have been seeing Hugh, a 16 year-old boy, for several months for help with a severe phobia about dogs. He has made great progress. He has been going out with a girl at his school who is 14 years old. He tells you that they have had sexual intercourse and asks you for advice on contraception.

Q1: What are the risk factors for sexually harmful behaviour present in Hugh’s story?

Q2: What are the child protection issues in this example?

Q3: What would you do about these issues?

Q4: If you have decided that Hugh’s disclosure should be taken further, what will you do about the issue of confidentiality?

The final scenario also concerns the issues of consensual sex, confidentiality and how to manage third party information. What you are considering is how to proceed when you the information you have received is not from any of the young people directly involved.

**Jane**

Jane is a 16 year-old girl who has been admitted to an in-patient unit for severe self-harming. She has cut and burnt herself over a number of years. Her father sexually abused her when she was a child and this has had a traumatic effect on her development and identity. She is very confused about her sexuality and is sometimes sexually inappropriate with the males in the unit. One of the other young people lets you know that she heard Jane and a 15 year-old fellow patient saying that they had sex while they were both on pass the other night.
Q1: What are the risk factors for sexually harmful behaviour present in Jane’s story?

Q2: What are the child protection issues in this example?

Q3: What would you do about these issues?

Q4: How would you manage the fact that the information you received came from a third party?

In this section we have looked at issues of child protection. You may have found that some of the scenarios created a difference of opinion amongst colleagues. There will often be differences of opinion in how to proceed when the safety of a child is involved. The important lessons from these scenarios is that the safety of the child is paramount but also there is no simple solution when thinking through and trying to resolve these issues.

Recommended reading


Bentovim, A (1992) Trauma Organised Symptoms: Physical and Sexual Abuse in Families London: Karnac


7.6 Risk taking and treatment

Being involved in treatment

Being involved in treatment can be a risk for children and young people. Whatever the kind of therapy children and young people receive there is an element of risk. When children and young people are involved in counselling or talking therapies, they have to take a risk that the person they are talking to can be trusted, and that they will maintain their confidentiality and treat them well and they understand what the child or young person is talking about.

Talking about how you feel and what you are experiencing can be difficult for adults — it is probably more difficult for some children and young people. Young people in particular are struggling to work out who they are, and giving up part of themselves to someone they don’t know can be a very risky process. We expect young people to reveal personal things about themselves and make them public, i.e. talking through their concerns about themselves. Being aware of how difficult it is for children and young people to talk about their feelings may help us to be more empathic. Creating a facilitating environment for a young person is really important, thinking about how you are going to establish trust and build up a relationship is central to working with young people. We bring our own assumptions to our meetings with children and young people. It is important that these assumptions don’t get in the way of building a trusting relationships, e.g. for lesbian, gay, bisexual or transgender young people, talking about their sexuality can be a risk. If the staff member assumes that young people are heterosexual by asking boys about their girlfriends and vice versa, then this does not allow for difference. Such an approach also gets in the way of building a trusting open relationship, where the young person can see, hear and feel they are valued [264].

You should reflect on how you feel about talking about your own feelings and what makes the process easier or more difficult.

Taking medication

Taking medication can be difficult for young people. There are obvious issues, such as the young person agreeing to take the medication, which is affected by the efficacy and side effects of the medication. But there are also particular issues that are connected to a young person’s identity — there is a risk for some young people that taking medication will affect the core of who they are; that taking medication will change them and they will no longer be who they were. There is a balance between managing symptoms, preventing the problem from re-occurring, and minimising side effects.

Too often, the debate around medication has become polarised and, in an effort to defend their own positions, practitioners have become rigid in their approach, not hearing the other side of the argument. An example of this is the position which says medication is bad for children and young people, that their brains are immature and that taking medication at such an age will have irreparable effects. On the other hand there are those who argue that the side effects of medication are relatively harmless and far outweighed by the benefits children and young people receive from treatment, and that we shouldn’t be too concerned about giving medication to children and young people.
The debate about treatment is very important. An example of its importance is that relatively little research is done on the effectiveness of medication on children and young people and certainly few long-term studies — and because of this, very few medications are licensed for children and young people, so we have to rely on findings from studies with adults.

Given the differing opinions there are around giving medication to children and young people, it is unsurprising that children and young people themselves sometimes have difficulty taking medication. You should familiarise yourself with the debate around medication. In the bibliography there are references to papers which take a particular position over the use of medication with children and young people. Select one of the papers and make notes about each of the papers and discuss your opinion with your supervisor.

Before you look at the literature you might want to examine your own opinions on giving medication to children and young people and think about what informed that opinion. This might be difficult to do but it is worth reflecting on.

Recommended reading

Kirsch, I and Sapirstein, G (1998) Listening to Prozac but Hearing Placebo: A Meta-Analysis of Antidepressant Medication Prevention & Treatment 1, Article 0002a The American Psychological Association


The National Institute for Mental Health have a good fact sheet on depression in children and adolescents which can be accessed at: http://www.nimh.nih.gov/healthinformation/depressionmenu.cfm


The 19th February 2005 British Medical Journal has three articles on medication and clinical practice.

Conclusion

In this chapter we have examined the concept of taking risks with children and young people. The area is quite complicated, with many different factors to be taken account of to examine in terms of risk from others, risk to oneself, and risk to others. Scenarios that are similar to those you have been presented with here will recur in practice. In fact the scenarios have been chosen because they resonate with CAMHS practice. It might be useful to keep a note of the scenarios which do recur, and reflect on how your opinions and actions change over time. Hopefully, reading this chapter will have given you an insight into the debate around risk, your own way of managing risk and give you some pointers for further reading.

If you are reading this conclusion having completed the whole package — congratulations! There will have been a considerable amount of work in finishing the training material. Having completed the pack you should have gained a firm grounding in working with children and young people in a mental health setting. Hopefully you can build on these foundations by further developing your knowledge and understanding of mental health issues with children and young people. An important part of this development will be accessing further training and theoretical knowledge. Continuing use of reflection and ongoing supportive relationships with your facilitator and colleagues will be important in developing your knowledge and skills over the years to come. Completing this package will hopefully be the start of a career in working with children and young people’s mental health and will be the foundation for future work.
SECTION FOUR

Appendix 1

Children’s mental health has recently become a national priority in Scotland, with new funding identified to promote their wellbeing. This package is one of several commissioned initiatives, funded by the Scottish Executive, to address one identified need: supporting skills development within Scottish NHS child and adolescent mental health services.

The SNAP report [8] has been highly influential in this development. Against a background of evolving legislation that had been designed to enshrine the rights of children in Scotland and to improve their general well-being, a widely ranging group had contributed over several years to the report, with an exclusive focus on children’s mental health needs. Its conclusions highlighted a capacity problem i.e. insufficient skills and resources were available across Scotland, but it was felt that this could be at least partly resolved if opportunities were taken for closer inter-agency working. In the words of the report, there could be, and should be, a shift of the centre of gravity (of mental health work) from specialised clinics toward community-based care. The detailed implications of its recommendations were examined out in a subsequent document for CAMHS in Scotland, Mental Health of Children and Young People: A Framework for Promotion, Prevention, and Care (October 2005) [9]. Implementation was expected to result in a more multi-disciplinary and holistic approach to children’s mental health needs.

Pediatric practice had received similar advice; e.g. an earlier child health report [265], emphasised the importance of a holistic approach to child health. Education too was expected to play its part in promoting children’s wellbeing, with far closer inter-agency working expected to result from the Integrated Assessment Framework initiative which was incorporated in the Education (Additional Support for Learning) (Scotland) Act 2004. It is too soon to know how this, and the developing Community Health Partnerships and Community Health & Care Partnerships, will ensure close working between public sector providers at a local level in Scotland, but the direction of travel is clear: more joined-up working between the public sectors involved in providing for children, a respect for multiple perspectives, and continued efforts to maximise the professional skills required to meet children’s needs.

The National Programme for Improving Mental Health and Well-being (www.wellontheweb.net) has also made young people’s health a priority. It has, for example, supported CAMHS’ staff to develop CD-ROMs and website developments for young people (e.g.www.stressandanxietyinteenagers.com). The support to individual CAMHS teams to undertake this type of work has been variable, but Choose Life initiatives have rolled out across Scotland, and HeadsUp Scotland has commissioned training initiatives on children’s mental health for non-NHS staff who work with young people.
One more major policy development also shaped this package, arising from the *Kerr Report* [25], which had considered the future shape of the whole of the NHS in Scotland. This report was quickly followed by guidelines that set out a clear set of intents for the Scottish NHS (*Delivering for Health*, 2005 [26]). Those of greatest relevance for CAMHS include two major shifts of emphasis in how NHS services should be delivered:

1. away from individual practitioners/practices towards team-based working; and
2. away from the traditional NHS focus on discrete illness/healthcare episodes towards anticipatory care and preventative work.

The second of these has considerable implications for CAMHS work, which should be easier than it would have been ten years ago since the published findings of the ONS national surveys of children’s mental health (e.g. on which subgroups of children are most at risk of problems, and what factors seem associated with service uptake). New guidelines from the Group for Healthcare Policy and Strategy on local delivery plans for Scotland in 2006-2007 are expected shortly. A web-based consultation exercise (which opened on 10th April 2006) on the new ‘action framework’ from the Children and Young People’s Health Support Group (CYPHSG) suggested a set of measurable improvements in health outcomes and health care services, along with target dates e.g. some expansion of CAMHS inpatient provision, a reduction of teenage pregnancy / smoking / alcohol use, etc (see [www.scotland.gov.uk/Publications/200604/071022450/0](http://www.scotland.gov.uk/Publications/200604/071022450/0)).

‘Closer to home’, another of the proposals was that by 2010, if not before, all new-to-CAMHS staff should receive, within a year of taking up post, the type of training contained in this package.

Finally, the Mental Health (care and treatment) (Scotland) Act 2003 has important implications for the care of young people with more severe mental health problems, the most immediate of which is to ensure they receive care that is appropriate to their age. However, although this has directly impacted on the work of CAMHS throughout Scotland, necessitating close links with general (adult) services, as relatively few new-to-CAMHS staff are likely to become directly involved in that work, the scope of this package has not extended to encompass it.
Appendix 2: Staffing of specialist CAMH services

Workforce percentages of five professional groups (there are many other professional groups working in CAMH and you might find it helpful to ask them to inform you on these issues. There was not room in this appendix to cover them all).

At 31.5.05, medicine, nursing and psychology accounted between them for 77% of the staff whole-time-equivalent hours.

Psychiatry: over 11.33%
Nursing: over 36.28%
Psychology: 29.51% (incl. trainees and assistant psychologists who represent 25% of the total number)
Occupational therapists: 4.10%
Social workers: 3.66%

(Data from Getting the Right Workforce, Getting the Workforce Right Strategic Review Document commissioned by the Scottish Executive, 2005, p.30-31.)

Background and training of the same five professional groups

Child and adolescent psychiatrists
Child and adolescent psychiatrists are qualified medical practitioners. After registration, they choose an area of medicine in which to specialise. This postgraduate training period as a Senior House Officer (SHO) usually lasts up to three years. It includes becoming a member of the Royal College of Psychiatrists (MRCPsych) after College examinations. To register as a specialist in child and adolescent psychiatry, supervised work in CAMHS as a specialist registrar (SpR) for at least three years must be completed, after which psychiatrists become eligible to apply for a consultant post. Additional experience in primary care, paediatrics, community child health services, or research is quite common. SpR training mainly focuses on assessment and treatment using psychobiological and pharmacological approaches, and includes training in at least two types of psychotherapy (child psychotherapy, family therapy, CBT or group psychotherapy).

Like many clinical psychologists, child and adolescent psychiatrists are experienced in disentangling the psychological and physical factors of illness (e.g. psychological consequences of physical illness, and the expression of psychological distress through the development of physical ailments). Consultant psychiatrists assume overall responsibility of those CAMHS patients who require hospitalisation, regardless of what additional treatment is provided by other CAMHS staff, and take the lead role in CAMHS work associated with the Mental Health Act.
Nurses
Nurses who work in CAMHS have usually done their initial nursing diploma/degree in either mental health or child health and are registered with the Nursing and Midwifery Council (NMC) as RN (Mental Health) or RN (Child Health). This initial qualification (usually a diploma, but increasingly a degree) did not include children and young people’s mental health as a mandatory subject until 2006. Before this date, the provision of teaching and practice experience in this subject was left to local initiatives and the availability of resources. An introduction to the subject and to child protection will now be part of all child health and mental health pre-registration training but practice experience will remain optional.

A number of courses in children and young people’s mental health are available to support the educational needs of nurses after registration, including degrees and qualifications in the areas of psychosocial interventions, family therapy, Cognitive Behaviour Therapy, counselling, group work, psychotherapy, interpersonal therapy etc. Nurses have to demonstrate to the NMC that they are taking part in continuing professional education in keeping with their field of practice.

Clinical psychologists
Clinical psychologists must have a degree in psychology followed by a doctorate in clinical psychology which equips them with the skills to contribute to clinical research. They must acquire clinically relevant practical experience before they enter training. Clinical psychology courses are accredited by the British Psychological Society (BPS), and graduates of accredited courses are eligible to register with the BPS.

Clinical psychologists receive a generic training across the lifespan, including work with children, adolescents and their families, adults, older adults and those with learning disabilities. Following qualification, they may choose to specialise in one of these groups or in working with specialist populations, such as people with neuropsychological, forensic or long-term mental health difficulties. Clinical psychologists are trained in a range of psychological theories and models, and their application across the lifespan. Once qualified, they may decide to undertake further specific training in one or more models of psychotherapy.

Occupational therapists
Occupational therapists have a professional qualification in occupational therapy, which can be a PGDip, a BSc, a BSc Hons or an MSc. This is a generic training for all areas of clinical work, across the lifespan. During their training, occupational therapists study the biological and behavioural sciences. They learn the core skills of the profession, which are the use of selected activities as a treatment medium, activity analysis and the assessment and treatment of functional capabilities. They also spend 1000 hours in a variety of practice placements which may include CAMHS. Occupational therapists beginning a career in CAMHS usually require post qualification experience in adult mental health or in paediatric services. Whilst some post-graduate occupational therapy courses include CAMHS modules, many occupational therapists specialise in the use of particular therapeutic models or treatment approaches such as play therapy, group work or psychodrama. All Occupational therapists are registered with the Health Professions Council and must show evidence of their continuing professional development.
Social workers
Social workers qualify with a degree in Social Work. To work in the mental health services, social workers train as Mental Health Officers (MHO). The main post-graduate courses (often up to Masters level) include child protection, criminal justice and work with vulnerable adults. Joint investigative interview training of child witnesses is also essential for children and family workers.

Social workers offer ongoing support to vulnerable children and young people, sometimes over long periods of time. They are often the first professionals to be involved with families at times of crisis. Generally, they manage their own caseload with clients in the community. Most social workers are employed by local authority departments, although some work for the NHS and can be attached to CAMHS.

There is often confusion between the roles of social workers in neighbourhood social work centres and those in multi-disciplinary mental health care teams. In the former, social workers who work with children focus on child protection and work with children and families in, for example, the areas of abuse, neglect and self-harm. They often provide family support as well as being responsible for protective measures. In the latter, social workers are members of the therapeutic team and may go on to train in family therapy, play therapy, solution-focused therapy, counselling or group work. However, they are especially mindful of child protection issues, working jointly with the team and their area social work colleagues [266].
**Subject index**

In order to keep the package uncluttered, all footnotes and most references to published texts have been removed from the main body of the package and replaced by a system of brief signposting, using numbers.

To read about a subject of interest to you, review the Index below; this either indicates the page number/s where the topic appears, or else refers to the number/s in the bibliography where recommendations of additional reading are given about topics that the package itself does not cover in detail.

The subject index works like this:

1. pages of the text wherever the topic is formally reviewed: page numbers in bold (e.g. 45-46)
2. any page of the text where the topic appears: page numbers in ordinary font (e.g. 12, 28, 45, 111)
3. topics not covered in the package: a number in brackets indicates where a published text can be found in the bibliography (e.g. [16] [37]).

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