# Component 4

## Helping children with mental health difficulties

## Summary of the literature

**KidsMatter Primary Component 4: Helping children with mental health difficulties**

Healthy development during childhood forms the foundation of mental health and wellbeing throughout life. This understanding has led childhood (birth to 12 years) to be considered a critical stage in the human lifespan. It is during this period that children begin to establish a sense of self, develop social and emotional competencies, form relationships with a wide range of people - including peers and adults other than family members - and begin to actively participate in family, school and community life. Increasingly, it is understood that experiences in childhood influence a range of outcomes later in life, including life satisfaction, parenting and employment (ARACY, 2008). Children who experience difficulties with their mental health experience considerable distress, as do their families and others who care for them. If difficulties persist, children are likely to have much poorer outcomes during adolescence and adulthood in a range of areas, such as academic and educational performance, employment opportunities, and personal relationships.

A significant number of the childhood years are spent in educational settings. Schools are therefore well-placed to support children to engage with their education, maximise their mental health, and minimise mental health difficulties and disorders. Comprehensive interventions, like KidsMatter, that address children's mental health on a whole-school level are most likely to assist in this task. The KidsMatter Evaluation of 100 school communities found, "statistically and practically significant improvements in students' mental health, in terms of reduced mental health difficulties and increased mental health strengths" (Slee, Lawson, Russell, Askell-Williams, Dix, Owens, Skrzpiec, & Spears, 2009). Additional analysis of data since the pilot of KidsMatter Primary has suggested that schools which implement the initiative well are likely to also have a positive impact on academic performance. For further information see KidsMatter research reports on the website:
www.kidsmatter.edu.au/primary/publications.

**Mental health, mental health difficulties and mental health disorders**

Mental health in childhood has been described as:

> *"A capacity to enjoy and benefit from satisfying family life and relationships and educational opportunities, and to contribute to society in a number of age appropriate ways. It also includes freedom from problems with emotions, behaviours or social relationships that are sufficiently marked or prolonged to lead to suffering or risk to optimal development in the*

*child, or to distress or disturbance in the family"* (Raphael, 2000).

There is great variability in the expression of emotions and behaviour during childhood. This can be due to factors such as temperament, cultural expectations, stage of development, family, school and community norms, as well as the type of experiences children encounter in the real world and, increasingly, in virtual worlds. In particular, children may display strong reactions to common life experiences or stressors, and experience considerable anxiety and fear in response to certain triggers which are considered developmentally normal and, in some circumstances, adaptive. In such cases, it may not be helpful to view children as having a problem with their mental health (Beesdo, Knappe & Pine, 2009). Rather, supportive approaches directed at alleviating the problem, or addressing the environmental stressor in some cases, should be used to promote the maintenance of mental health throughout stressful situations (Horwitz, 2007). In a school context, such approaches can be developed in consultation with the child, family and student wellbeing support staff. In this way, the most useful strategies to best meet the child's needs during such times can be developed.

Culture appears to play a part in people's understandings of child behaviour and emotional expression, and in determining what is considered to be cause for concern. The experience of some emotions and their expression - such as anger and aggression or shyness and inhibition - may be seen as either socially-acceptable or as indicative of a possible mental health difficulty and cause for concern. The perspective depends upon the cultural norms and values of those in judgement, which can result in a variety of understandings and tolerance levels of behaviours (Rubin, 1998). Such differences in understanding can lead to the behaviour of children from minority cultural backgrounds being perceived differently to those from majority groups (Bernard, 2004; Brantlinger, 2003). The role of teachers cannot be ignored in these considerations, including their own cultural background, culturally-embedded expectations, and social and emotional competence (Han, 2010).

The terms *mental health difficulties* or *mental health problems* in childhood refer to a broad range of emotional and behavioural difficulties, which are relatively common. At present, there are no universally-accepted definitions or criteria for determining the point at which emotional or behavioural symptoms or patterns become difficulties that require intervention. For some children, early or milder signs that are left unattended may progress to a diagnosable condition, further emotional and behavioural difficulties, or entrenchment of concerning patterns of thinking or responding to their

social environment (Rubin, LeMare & Lollis, 1990; Rutter, 2011; Sameroof & Fiese, 2000). Whether or not a child has an identifiable mental health problem or even a diagnosable disorder is somewhat irrelevant for school staff in the first instance. Where it appears a child is experiencing significant distress or disruption to their academic or social functioning, action is best taken to identify and attend to the child's or the family's social and emotional needs. The most appropriate action for school staff will be determined in line with the schools' student wellbeing policies, duty of care requirements, and referral pathways and supports within and outside of the school.

*Mental health disorders* tend to describe a defined set of behaviours which cause significant distress or functional impairment, are not transient or typical responses to everyday stressors, and meet criteria for an identifiable disorder as described in a standard diagnostic manual, such as the Diagnostic and Statistical Manual of Mental Disorders (Raphael, 2000).

Mental health difficulties are present in childhood. In Australia, the first nationwide survey of mental health and wellbeing of children was conducted in 2000 with a sample of 4509 children aged four to 17 years (Sawyer, et al, 2000). Results indicated that, on average, one in seven children was experiencing a mental health difficulty, a prevalence estimate of 14 per cent.

Mental health difficulties in childhood can be classified into two broad types: externalising and internalising problems. It is not uncommon for children to display symptoms of both internalising and externalising problems. Externalising problems are characterised by an under-controlled behavioural pattern, a tendency to act out and respond in a way that disturbs or is harmful to others. Some of the most common mental health disorders considered to be externalising problems are Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder and Conduct Disorder (Halfon & Hochstein, 2002). Internalising problems are described as over-controlled or inhibited behaviours, presenting commonly as anxiety and depression (Zahn-Waxler, Klimes-Dougan, & Slatetr, 2000). They are emotional responses which primarily affect the child and, less so, others around the child making the symptoms less noticeable and disruptive in the school setting (Gresham, et al., 1999). The nature of these characteristics can mean that internalising problems are under-identified, under-referred and therefore less likely to receive specialised mental health services (Wu, et al;. 1999). Identification of depression, for example, can be difficult as it can present differently at various stages of development. In younger children, for instance, it may present through symptoms such as stomach pain and headaches, sadness, irritability and behavioural disturbances. Loss of interest in social activities may also be evident in older children (Jain, Jain & Islam, 2012).

## Influences on children's mental health and the development of mental health disorders in children

Research has indicated a range of risk factors that are likely to increase the chances of children experiencing poor mental health. There are also a number of protective factors, characteristics or conditions that can improve children's resistance to such risk factors. Protective factors act to strengthen children's mental health and wellbeing, making it less likely that they will develop (or less severe, should they develop) mental health difficulties or disorders.

Risk and protective factors can be identified in relation to individual skills, needs and temperament, familial circumstances and relationships, school context, specific life events and social environment. This grouping of factors reflects a socieocological model of child development which acknowledges the significant influences of family, school, community and broader societal factors in which children live and grow. It should be noted that the presence of risk factors does not mean a given child will experience mental health difficulties, just as a lack of apparent risk factors does not necessarily mean that mental health difficulties will not develop. However, research at present does suggest that the likelihood of mental health difficulties occurring is significantly increased when multiple risk factors are present or when specific factors such as abuse have occurred. As it can be difficult or impossible to change some risk factors, efforts to build protective factors can serve to mediate the impact of risk factors. Examples of risk factors include: impulsivity; disability; a difficult temperament; family disharmony, instability or break up; harsh or inconsistent discipline style; peer rejection or bullying; inadequate or hash school discipline policies and practices; life events such as physical, sexual or emotional abuse or the death of a family member; and societal factors such as discrimination or isolation (Commonwealth Department of Health and Aged Care, 2000; Spence, 1996).

Protective factors are important in recognising and drawing upon the strengths of the child, family, school and community. Examples of protective factors include: an easy temperament; school achievement; a positive coping style; family harmony and stability; strong family norms and values; a positive school climate that enhances belonging and opportunities for success and recognition of achievement at school; involvement with significant others; participation in community networks; and economic security (Commonwealth Department of Health and Aged Care, 2000; Spence, 1996). These factors can provide the necessary protection in the face of other aspects of adversity to maintain good mental health and wellbeing, or to help a child with mental health difficulties return to and maintain a state of wellbeing – a capacity often referred to as resilience.

The multitude of risk and protective factors identified shows the breadth of influences on children that either increase vulnerability to or protect against mental health difficulties. Implicit in understanding the risk and protective factors framework is the recognition that there are multiple pathways to mental health difficulties, and that differing mental health presentations can share similar risk factors (Greenberg, et al, 2001). Some children can have multiple risk factors and maintain good mental health. This appears to be due to significant protective factors and the individual's disposition. Family factors are considered crucial during childhood in determining outcomes in adulthood. Four key family related factors which commonly lead to poorer outcomes in adulthood are poverty, ineffective or uncaring parenting (lack of warmth and caring), child maltreatment, and marital or family conflict (Doll & Lyon, 1998). They highlight the fundamental importance of bonding and attachment relationships with primary care-givers and the need for stable and organised environments for child development. Children also benefit greatly from the stable and organised school environment and the opportunities there to develop trusting relationships with school staff.

It has been recognised for some time that there are population groups within Australia that experience high levels and unique combinations of risk factors, placing them at increased risk of mental health difficulties and disorders. This includes Aboriginal and Torres Strait Island people, and people from culturally and linguistically diverse backgrounds, including refugees. Research into the extent and nature of such difficulties are limited by cultural differences between standard mental health frameworks typically used in research, and the ways that mental health difficulties are understood and experienced by Aboriginal and Torres Strait Island people. Research that has been conducted by the Western Australian Aboriginal Child Health Survey found that Aboriginal families had experienced three or more major life stress events in the 12 months prior to the survey. In addition, 22 per cent of children had experienced seven or more such events (Zubrick, et. al., 2005). These children were significantly more likely to experience mental health difficulties. The study found that 26 per cent of Western Australian Aboriginal children between the ages of four and 11 years showed signs of serious emotional or behavioural disorders (the rate for non-Aboriginal children was 17 per cent). For further information about the social and emotional wellbeing of Aboriginal children, see *Promoting the mental health and wellbeing of Indigenous children in Australian Primary Schools* on the KidsMatter website (www.kidsmatter.edu.au/primary/publications).

The psychosocial wellbeing of refugees resettling in Australia was considered in a literature review prepared by the Australian Psychological Society (Murray, Davidson & Schweitzer, 2008 – see the Australian Psychological Society website:

www.psychology.org.au/Assets/Files/Refugee-Lit-Review.pdf). The authors note that the refugee experience can be varied, and raise particular concerns in relation to the psychological vulnerabilities of children held in immigration detention. An extensive review of local and international research into the mental health status of children and adolescents who were refugees, or were detained in the course of claiming refugee status, concluded that symptoms of post-traumatic stress were common (Thomas & Lau, 2002). Symptoms in school aged children included: flashbacks, exaggerated startle responses, poor concentration, sleep disturbance, complaints of physical discomfort, and conduct problems. Children who were separated from parents or other caregivers were more likely to exhibit symptoms of depression. For further information about supporting students of refugee background, see *School's in for Refugees. A whole-school approach to supporting students of refugee background* (Grant & Francis, 2011, Foundation House).

Hyperactivity, aggression and antisocial behaviour are common behavioural outcomes seen in traumatised children, and can be misdiagnosed as symptoms of Attention Deficit Hyperactivity Disorder (Thomas, 1995). Trauma responses in children can occur following a wide range of events or experiences, including chronic abuse or neglect, painful medical interventions, one-off traumas such as disasters or accidents, and traumatic experiences at a community level. For an extensive review of the impact of traumatic experiences on children and the role that teachers can play to support children, see *Calmer Classrooms. A guide to working with traumatised children* (Child Safety Commissioner, www.kids.vic.gov.au).

Psychosocial stressors such as bullying and exclusion can also lead to a range of mental health difficulties. They can precipitate the onset of a mental health disorder, or contribute to its maintenance, particularly where the problem is persistent or long-lasting (Osman, 2000; Maag & Reid, 2006). In childhood, bullying and social exclusion are considered the most common forms of chronic stress outside of family relationship stressors, and are linked to mental health difficulties in childhood (Bhardway & Goodyer, 2009; Heim & Binder, 2012). Schools can play an active role in ensuring a safe and supportive environment for students by working to promote respectful relationships, prevent incidents of bullying and, where necessary, respond swiftly and effectively to incidents of bullying which may arise. For further information see the *National Safe Schools Framework*: www.deewr.gov.au/Schooling/NationalSafeSchools/Pages/nationalsafeschoolsframework.aspx.

## Responses to children's mental health difficulties and disorders

The extent and experience of mental health difficulties in childhood have been minimised throughout history. For example, 20 years ago professional opinion was that children did not experience depression. A commonly held public opinion still is that children will outgrow any mental health difficulties, particularly behavioural disruption. However, reports from the Australian Temperament Project found that 50 to 60 per cent of children exhibiting signs of internalising and/or externalising problems at three or four years of age continued to show signs of these problems when reassessed at age 11 or 12 years (Prior, Sanson, Smart & Oberklaid, 2000). For further information about the Australian Temperament Project, see www.aifs.gov.au/atp/.

In addition, many mental health disorders previously thought to appear in adulthood have now been found to originate much earlier, sometimes in childhood and adolescence (Kessler, Berglund, Demier, Jin, Merikangas & Walters, 2005). This suggests that early recognition of children's mental health difficulties is essential to ensure children's enjoyment of life and to adequately meet their developmental needs. It is also critical in preventing longer-term impacts on children's development, engagement within the school setting, ability to learn, and the capacity to form age-appropriate relationships with peers and adults.

### The role of schools in responding

Schools are considered the principal environment of children when they are away from home. A body of research has identified factors within the school setting, which either positively or negatively influence children's mental health and wellbeing (eg Kay-Lambkin, Kemp, Stafford & Hazell, 2007). This has led to a wide range of approaches and interventions in schools. Interventions have often shown limited effectiveness where they operate in isolation to address what are in effect complex, multi-factorial problems. Accordingly, the need has been identified for comprehensive whole-school community initiatives such as KidsMatter (Graetz, et al, 2008).

Teachers are one of the few professionals involved with the population of children on a daily basis. Unique to their role is also the need to form positive, collaborative working relationships with families over a prolonged period of time. In fact, teachers are often consulted by parents who have concerns about their children's behaviour or development (Dwyer, et al., 2005; Shanley, Reid & Evans, 2008). The significant amount of contact teachers have with their students and families, along with their exposure to many children of similar ages, leaves them well-placed to notice potential signs of difficulties that may fall outside typical

development (Herman, et al., 2009). Teachers are also relied upon as sources of referral to child and adolescent mental health services, particularly for mental health difficulties that are first noticed in the school environment (Appleton, 2000).

Schools can also support children and families to seek additional help. Help-seeking refers to the act of seeking assistance from another, such as a family member, friend and/or professional, so that support, advice or help can be obtained (McCarthy, 2008; Hinson & Swanson, 1993). Only one in four children with a mental health difficulty accesses help. Children who do access help are more likely to be those with severe problems (Sawyer et al, 2001). Traditional models of help-seeking proposed a linear process, in which a person must first recognise a problem, decide to seek help, and then select a source of help (Fisher, Weiner & Abramowitz, 1983). More recently, linear approaches to help-seeking have been replaced with more complicated models. These reflect pathways to help that are often varied and disorganised. Contemporary help-seeking models outline the multiple influences which dynamically affect whether parents and children seek help and access mental health services (eg Gateway Provider Model, Stiffman, Pescosolodo & Cabassa, 2004). Decisions to seek help are influenced not only by perceived need, but also by knowledge and accessibility of available services, and the extent to which environments contain barriers to help-seeking (Stiffman, et. al., 2004). Schools can assist in addressing some of these barriers.

Effective communication between families, school staff, and service providers can help in the mutual understanding of the child's and family's needs. It can also assist in the access of early support for children experiencing mental health difficulties and disorders, and facilitate the coordination and transfer of strategies being developed within one setting to the other (Gopalan, Goldstein, Klingenstein, Sicker, Blake & McKay, 2010; Webster-Stratton, Reid & Stoolmiller, 2008; Shucksmith, Jones & Summerbell, 2010: Herman, Borden & Hsu, 2011). Efforts from school staff to build working partnerships and collaborate effectively with parents and carers enables conversations about children's mental health needs to occur more easily. Such efforts also facilitate support for families in seeking and accessing help for their children and themselves. KidsMatter Component 3: Working with Parents and Carers assists schools in building these partnerships.

Where a child has come to the attention of the school regarding possible mental health difficulties or a disorder, there can be a push by some for the child to receive a diagnosis of a mental health disorder and reluctance from others to diagnose or label. Benefits to diagnosis include a potential improvement in care and the selection of more targeted and appropriate

interventions known to be of benefit to people experiencing specific disorders (Stein, Phillips, Bolton, Fulford, Sadler, & Kendler, 2010: Odom, Collet-Klingenberg, Rogers & Hatton, 2010: Lewin & Piacentini, 2010: Barrett, Farrell, Pina, Peris & Piacentini, 2008; McHugh & Barlow, 2010, Smolders, et al., 2009). Diagnosis can also facilitate access to specific types of support (such as integration support within education systems) which is only available when certain criteria, including diagnosis, are established.

There are problems that can be associated with having a diagnosis. They include: a potential increased focus on the signs and symptoms of the disorder rather than understanding and appreciating the whole child; the diagnostic label providing justification for problem behaviour without considering ways of gradually improving the difficulty; and assuming that certain features often associated with a diagnostic label apply to all children with that diagnosis when they may not be relevant to the particular child (Bogels, Lehtonen & Restifo, 2010). A focus on the negative aspects of the label can also mean that adults and other children view the child and his or her behaviour more negatively than they otherwise may (Hinshaw, 2005).

KidsMatter Primary does not screen or diagnose children. It seeks to provide school staff with the capacity to recognise when a child is experiencing emotional and behavioural difficulties and strategies for how best to support the child and family. KidsMatter seeks to focus on children whose difficulties are causing distress and impacting on their capacity to engage in their schooling, as well as peer and family relationships. Working closely with families is important so that concerns can be discussed and options for support canvassed. Schools can also benefit from partnerships with community and health services, as they are often available to provide advice to schools on supporting students with mental health difficulties and disorders whilst at school. Children with mental health difficulties benefit most when families, school staff and mental health practitioner(s) work collaboratively to support their mental health and wellbeing and maintain their engagement with schooling.

In attending to mental health difficulties and disorders of childhood, *promotion, prevention and early intervention* are three terms which are used in research and the development of programs and interventions. They are often used together but refer to different processes, goals and target groups. KidsMatter uses this approach in its work with schools. *Promotion* refers to efforts of facilitating the development of the skills of individuals, and influencing their environments, in ways which are known to promote and maintain mental health. These approaches are generally *universal*, that is, they are interventions which involve all the people in a particular target community. The target community can be a school, neighbourhood or broader geographical area or

a targeted group of people with particular characteristics. *Prevention* refers to facilitating the development of the skills of individuals and influencing their environments in ways which are known to reduce the risk of them progressing to, or developing mental health difficulties or disorders. These approaches may be *universal,* and not directed at individuals or groups based on certain risks. Alternatively, they may be *targeted,* in that they identify and specifically involve those considered at-risk of developing mental health difficulties or disorders through some known risk factor (such as the experience of parental separation or bereavement).

*Early intervention* in schools refers to treatments and interventions targeted specifically at those individuals identified as having signs or symptoms of a mental health difficulty or disorder. It can be defined as efforts taken to prevent the full onset of a mental health disorder by early recognition and management of symptoms or of providing intervention to assist in recovery before mental health difficulties or disorders become entrenched and disrupt education and relationships. Early intervention strategies have been shown to produce significant improvements in mental health. KidsMatter does not provide assessment, treatments or interventions, rather supports school staff and families to recognise and respond appropriately to signs of mental health difficulties in children.

**Conclusion**

Schools, despite their best efforts to prevent mental health difficulties and disorders in children, are likely to have children within their community who are suffering from mental health difficulties. Research indicates that the most prevalent of mental health disorders in childhood - anxiety disorders, behavioural disorders and depression - are also highly dependent on environment and relationship-based factors. As such, they are responsive to changes in these domains. Research also suggests that within the primary school-age group, both universal and targeted interventions involving children directly yield significant and positive results.

Early identification of signs of mental health difficulties in children benefits students, families and schools in numerous ways, including: improved quality of learning resulting from improved student mental health; decreased mental health difficulties; reduced behavioural difficulties; and improved school attendance. The ability to identify signs early will come from positive teacher-child relationships and the teachers' extensive knowledge of the child and their circumstances. Collaborative relationships between teaching staff and parents - where a shared understanding of the child's and family's needs can be developed and suitable support and/or onward referral to the most appropriate and accessible service can be

made - offer the best outcomes for children, parents and schools.

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