WHAT WORKS IN PROMOTING CHILDREN'S MENTAL HEALTH: the evidence and the implications for Sure Start settings

CONTENTS:

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WHAT WORKS in PROMOTING CHILDREN'S MENTAL HEALTH: the evidence and the implications for Sure Start programmes

Introduction

1.1 This paper focuses upon the prevention of what can broadly be called mental health problems in children and on intervention at the early stages of such problems. It summarises the currently available evidence on the effectiveness of preventive and early intervention programmes and service approaches, and the implications for Sure Start programmes. For this purpose, the evidence presented here focuses on work with parents-to-be, parents, and children of pre-school age particularly,with the mother/infant dyad.

What is meant by mental health in children?

1.2 It is as difficult to define mental health as it is health in general, but it is widely agreed that in children it is indicated by:

- a capacity to enter into and sustain mutually satisfying personal relationships;
- continuing progression of psychological development;
- an ability to play and to learn so that attainments are appropriate for age and intellectual level;
- a developing moral sense of right and wrong;
- the degree of psychological distress and maladaptive behaviour being within normal limits for the child's age and context (NHS Health Advisory Service, 1995, p. 15).

1.3 Mental health problems and disorders in children manifest in their behaviour, the way they feel, and the extent of interference with the child's functioning and normal processes of development. Problems are distinguished from disorders in being less severe, persistent and complex. A useful definition of mental health (or psychiatric) disorder was given by Rutter and Graham (1968) as:

"An abnormality of emotion, behaviour or relationships which is developmentally inappropriate and of sufficient duration and severity to cause persistent suffering or handicap to the child and/or distress or disturbance to the family or community".

How this relates to Sure Start

1.4 Thus, it can be seen how central mental health is to the aims of Sure Start programmes in "promoting the physical, intellectual and social development of babies and young children – particularly those who are disadvantaged - so that they can flourish at home, when they get to school

and during later life" (Sure Start Core Brief, 1.04.04) and in achieving the Sure Start PSA performance targets:

PSA target: to achieve by March 2006 **"an increase in the proportion of young children achieving normal levels of personal, social and emotional development".**

What is meant by prevention and early intervention?

1.5 Prevention can be seen as a four-step continuum, linked to when intervention is offered in relation to the development of problems:

1. Universal public health promotion.
2. Targeted intervention, for instance at the youngest ages.
3. Selective intervention at an early stage in the onset of identified problems.
4. Treatment for established disorders, with the aim of reducing their severity, duration or recurrence, and the development of complications.

1.6 What is generally termed primary prevention (step1 on the continuum above) attempts to intervene with the general population to preclude the possibility of problems developing in the first place. Secondary prevention – which essentially equates to early intervention - encompasses steps 2 and 3 above, where a child's problems are likely to be apparent but are not manifest as a defined mental health disorder. Step 4 on the continuum can be termed tertiary prevention and is a key element in the treatment of disorders.

What is meant by 'what works'?

1.7 The 'what' in this phrase refers to the interventions, service approaches and programmes aimed at prevention. These are discussed below. 'Working' refers to improvement in outcomes for the child. But not only for the child: it is now well recognised that positive outcomes from preventive interventions may be achieved in a number of domains in a child's life and that these may benefit the child directly and indirectly, as well as leading to wider benefits for the child's mother, his or her family, the school and the community (Hoagwood et al, 1996).

1.8 Five main types of outcome for the child can be expected:

1. A change in the symptoms of mental health problems, maybe to the extent that a diagnosed disorder can no longer be said to be present.

2. A change in the child's capacity to adapt to the psychosocial environment; in other words, how well a child functions according to what may be expected for his or her developmental stage

3. A change in the child's cognitive and emotional capacities; these

probably underpin both symptomatology and adaptation and include understanding emotions, understanding mental states in self and others, forming emotional bonds and making moral judgments.

4. Changes in the contextual influences which may have transactional relations with the child's problems, since, in the development of mental health problems, it is assumed that there are interactions between the child's mental state and behavioural predisposition and the reactions of the environment to this child over time. For example, research on conduct disorder has indicated how risk factors, such as the child's temperament and parents' personal and interpersonal problems (e.g. maternal depression) may interact to cause increasingly difficult behaviour. The caregiver's failure to cope with the oppositional behaviour of the child may be further aggravated by the absence of social support and a high level of psychosocial stress associated with the environment in which the family lives. Thus the contextual influences which may have transactional relations with the child's problem include parents, family relations, characteristics of the community and the child's school, as well as more general cultural factors.

5. Changes in the use of services – for example, home-based preventive interventions implemented in early childhood - may have the power to reduce child maltreatment and thus lessen the pressure on child welfare services.

These different types of outcome and the ways in which they can be measured are discussed fully by Professor Fonagy (Fonagy et al, 2002, chapter 1).

Sources of evidence for what works

1.9 The evidence presented in this paper is taken almost entirely from two recent reviews:

(i) Peter Fonagy, Freud Memorial Professor of Psychoanalysis at University College London, reviewed the evidence for the effectiveness of preventive interventions for child and adolescent mental health to inform the Acheson report on Health Inequalities, that was commissioned by the new Labour Government in 1997 (DoH, 1997). The evidence was not published as such, although much was covered in a seminal paper (Fonagy, 1998). The material formed the basis for a chapter on prevention in a systematic review of the outcomes of treatments for all psychiatric disorders in childhood, published on a Department of Health website (Fonagy et al, 2000 and 2001).

(ii) Professor Jacqueline Barnes, a core investigator for the National Evaluation of Sure Start at the Institute for the Study of Children, Families and Social Issues at Birkbeck College London has published a review on Interventions Addressing Infant Mental Health Problems (Barnes, 2003),

based on a more detailed review for the Mental Health Foundation (Barnes and Freude-Lagevardi, 2002). This focuses on interventions in infants and their mothers, and organises the material in terms of the psychological theory underpinning these interventions.

1.10 There is a great deal of congruence in the conclusions drawn from these sources, so that relatively confident statements can be made about the efficacy of a variety of preventive and mental health promoting strategies in children and their families. And a major meta-analysis of primary prevention studies for the mental health of children and adolescents (quoted in Fonagy et al, 2000 and 2001) showed that effects, such as enhancing competence and reducing problems, were comparable in size to those reported for other types of psychological, health educational and behavioural interventions, e.g. to prevent smoking and alcohol use in children.

The importance of prevention and early intervention

The general case for the prevention of mental health problems in children rests on the following well established facts:

2.1 The prevalence of disorders is high: 10.4% of children, aged five to 15 years old, in England, Scotland and Wales, have been found to have a diagnosis of mental disorder, based not just on symptoms, but on evidence of distress or interference with personal function (Meltzer et al, 2000). Prevalence rates are higher in adolescents than in younger children. But psychiatric disorder has been clearly demonstrated in very young children. In inner London, Richman and colleagues (1975) found moderate to severe disorders in 7% of three year olds and mild disorders in 15%.

2.2 A significant rise in the prevalence of psychosocial disorders - depression, eating disorders, substance misuse, suicide and suicidal behaviour, crime and conduct disorders - in young people aged between about 12 and 26 years, has been documented in Western developed countries, including Britain, since the end of the Second World War (Rutter and Smith, 1995).

2.3 Only a relatively small proportion of children with significant mental health problems and disorders find their way to specialist mental health services; this was found to be c.20% in the UK survey quoted above (Meltzer et al, 2003). It is estimated that as many as 60-70% of children and adolescents who experience clinically significant difficulties have not had appropriate interventions at a sufficiently early age.

2.4 The poor long-term outcome of untreated mental illness, such as schizophrenia, is also now increasingly recognised as causing disruptive behavioural problems. Even emotional disorders of childhood, which were traditionally thought to remit spontaneously, have been found to have poor

recovery rates – mostly around 50%. In the UK national survey follow-up, a quarter of the children who had a clinically-rated emotional disorder – anxiety or depression - at the first interview in 1999, were also assessed as having an emotional disorder three years later; this applied to 43% of those with conduct disorder (Meltzer et al, 2003). A review by Campbell (1995) showed that about two-thirds of three year-olds who show significant psychiatric disturbance still have difficulties at eight or 12 years of age, and that this applies particularly to violent conduct disorder which is of the greatest cost and concern to society. Conduct disorder, with many other childhood disorders, progresses beyond adolescence to mental illness in adulthood, e.g. disruptive behaviour to antisocial personality disorder, and depression to affective disorders in adulthood.

2.5 Children who do not do well at school, whether because of low IQ or a specific learning disorder, are at increased risk (as high as 40%) of mental health problems. Difficult behaviour is the most common reason for children to be excluded from school, and the risks of further mental health problems are high among these children (Barnes, 1998). In a national survey, behavioural problems were found to be the most common disabling condition that limited the capacity of children aged up to 15 to carry out daily activities (Bone and Meltzer, 1989). Poor school results, and the low self-esteem that they create, can affect future employment prospects and increase the risk of further psychological problems. Friendships may be difficult, leading to social isolation, which can only make things worse. The chances of making satisfying long-term relationships may suffer and the ability to act as a competent parent may be undermined, increasing the risk that a cycle of psychological and social problems will be repeated in the next generation.

2.6 Young people in the criminal justice system are also highly vulnerable with respect to mental health problems (Kurtz et al, 1998). The rate of mental health problems is high in young offenders, particularly persistent offenders (Hagell and Newburn, 1994). A diagnosis of a primary mental disorder was found in one-third of young men aged between 16 and 18 years sentenced by a court; screening of ten to 17 year-olds attending a city centre youth court revealed disturbingly high levels of both psychiatric and physical morbidity, including learning difficulties, mood disorders, epilepsy, frequent use of alcohol and illicit drugs, and mental illness (studies quoted in Kurtz et al, 1998).

2.7 Recent research has shown the heavy financial costs associated with mental health problems in children, which fall on many agencies. In a comparative study, Scott and colleagues (2001) found that costs for the use of public services (excluding private, voluntary agency, indirect, and personal costs) by age 28, of children who had been identified with conduct disorder at age ten, were ten times higher than for those with no problems, and 3.5 times higher than for those with less severe conduct problems. These authors conclude that antisocial behaviour in childhood is a major predictor of how much an individual will cost society, that the cost is large and that it falls on many agencies.

2.8 For many mental disorders of childhood, treatment interventions are relatively ineffective (Fonagy et al, 2002).

2.9 Data on developmental pathways to mental health problems are the key for the appropriate targeting of interventions in early childhood. The basis for prevention is the ability to reduce risk or strengthen protective factors in the developmental causal chain of a disorder. And much has been learnt about risk and protective factors for almost all child mental health disorders since the 1960s, identifying, in a number of instances, which of these risk or protective factors can be modified by interventions.

2.10 Some of the strongest evidence for preventive, and for early, intervention comes from the recent discoveries concerning 'sensitive periods' in the development of the central nervous system (CNS). This has now been demonstrated in a number of areas, including emotional reactivity, self-organization, motivation, relationships, and the irreversible damaging impact of certain types of early sensory experience (more specifically, the overwhelming destructive effect of early emotional stress and the sensitization to – or kindling effects of – these experiences). There can be no doubt that the early maltreatment of a child has profound neuropsychological as well as behavioural sequelae.

Preventive approaches

Strategies for prevention

Three strategies of prevention may be differentiated, based on the target group: universal, selected, and indicated.

3.1 *Universal strategies of prevention* are directed at the general population. Although the population is usually not pre-selected, high risk populations may be identified. But unlike selected intervention programmes, universal preventive strategies do not target specific types of individual within the population who have characteristics which define them as being at high risk from developing the disorder. It is the population that may carry the risk, which is generally relatively low in these interventions, not the individual within the population. The programme is delivered universally. For example, the Baltimore Primary Mental Health Project (Kellam et al, 1994a) delivered a universal preventive intervention to a population of inner city children, designed to address school failure and the development of behavioural problems. All children entering the first grade in the selected schools were randomised into intervention and control groups. The intervention group received support in early reading skills to support academic self-efficacy and a classroom-based programme aimed at teaching problem solving skills and rules to guide interpersonal behaviour. Interventions in this and similar programmes are shown to be increasingly (Stoolmiller et al, 2000) or uniquely (Kellam et al, 1994b) effective for high-risk children. However, because within a universal prevention study, extremely large numbers of subjects are

required in order to show a statistically significant reduction in the incidence of new cases, we do not know from current studies the relative impact of universal prevention interventions on high and low-risk young people or the impact of selective interventions for high-risk young people relative to universal ones for low-risk young people (Tolan and Gorman-Smith, 2002).

3.2 *Selected prevention strategies* are applied to individuals who are markedly at risk of developing disorder or show very early signs. Interventions tend to focus on the reduction of risk factors and the strengthening of resilience. Risk is obviously higher in these selected groups. Often, this comes from the concentration of risk factors rather than the intensity of any one factor. Hence poverty, unemployment, inadequate transport, sub-standard housing, parental mental health problems, and marital conflict may come together to blight a particular child and may be addressed in preventive programmes. For example, the Elmeira Project (Olds et al, 1994) found that an early, intensive, nurse home-visiting intervention worked well to prevent child maltreatment in the early years and delinquency on 15-year follow-up, but only with those at the highest risk (very young single mothers with low socio-economic status).

3.3 *Indicated interventions* in part mirror tertiary prevention, and are aimed at groups with specific disorders, where early symptoms are evident but the full disorder has not yet developed. For example, treatment of children's attention deficit with stimulant medication can be thought of as a method of prevention for both oppositional defiant disorder and depression, since ADHD is a risk factor for these disorders. It is often hard to distinguish selected and indicated prevention interventions. Thus, parenting training might be involved in both selected and indicated prevention of conduct problems. In practice, modern intervention programmes tend to combine universal, selective and indicated prevention into complex packages, for example the Conduct Problems Prevention Research Group (2002).

Theoretical models

3.4 The review by Professor Barnes covers the following theoretical models for early intervention:

- Parent-child bonding
- Psychodynamic (brief) parent-infant psychotherapy
- Infant-led psychotherapy
- Attachment theory
- Developmental theory – infant capability
- Pedagogical – parent as teacher
- Interactional-relational guidance
- Transactional theory
- Support/family self-sufficiency and empowerment
- Ecological theory

3.5 *Parent-child bonding*

Extra mother-child contact immediately post-birth has been used to promote

bonding and enhance the mother-infant relationship. However, little is known about what transpires during these extra times together.

3.6 *Psychodynamic parent-infant psychotherapy*
Parents and infants are worked with together to modify the maternal representation of her child and of herself, through interpreting what mothers project onto the child and the link between present and past conflicts. With roots in psychoanalytic and object relations theory, there is an assumption that the mother's dysfunctional beliefs and assumptions about her relationship with her parents influence any difficulties she has with her infant. Brief parent-infant psychotherapy aims to enhance reciprocity, communication and mutually shared pleasure between mother and infant.

3.7 *Infant-led psychotherapy*
This relatively recent intervention strategy for mothers and their infants involves setting aside a regular period in which the spontaneous and undirected activity of the infant is acknowledged by the mother in much the same way as a therapist does with an adult patient. The aim is to enhance mutual sensitivity and responsiveness. By learning to relax with the infant and to inhibit intervening, the mother begins, more objectively, to appreciate her infant's signals and individuality.

3.8 *Attachment theory*
Interventions based on attachment theory:

- will increase mutual sensitivity and responsiveness;
- focus on the relationship between the infant and the mother;
- use the infant's capacity to play an active role in his/her own development and the relationship with the mother;
- take into consideration the mother's internal working model of her infant and their relationship, and how her own attachment experiences may be influencing her relationship difficulties with her infant;
- include a therapist who provides a secure base for the dyad.

The aim is to alter the maternal view (representation) of her infant by identifying the child's active role in relationships and enhance responsiveness and consistency, so that the infant will develop in a more secure context.

3.9 *Development theory – infant capability*
The Brazelton Neonatal Behavioural Assessment Scale (NBAS) (Brazelton, 1973) highlights infant capabilities and reactions to the environment. The NBAS has been used with parents in hospital, in the immediate post-natal period, as a means of enhancing and strengthening parental interest in their child. Parents are able to see the newborn's ability, skills and sensitivity to the environment, and are encouraged to understand the infant's characteristic body tone, control of feelings and ability to be soothed. The aim is to improve parents' responsiveness by alerting them both to the interactive abilities of their newborn and to areas of relative weakness. The NBAS has been used with high-risk groups such as premature infants and teenage mothers (Widmayer and Field, 1981).

3.10 *Pedagogical – the parent-as-teacher model*
This model is sometimes referred to as 'Developmental Guidance', and concentrates on activities to enhance infant development and the mother-child relationship through sensitive reactions. The curriculum-led activities aim to increase parents' knowledge of child development, and increase their feelings of competence and confidence.

3.11 *Interactional - relational guidance*
Offered in the context of psychotherapy, this is designed to help mothers increase their knowledge of their infant on the basis of spontaneous interactions. Thus, it is more individualised and flexible than developmental guidance. The approach always includes the infant and is aimed at modifying patterns by making mothers aware of their interactive styles, emphasising harmonious interactions over pathological ones.

3.12 *Transactional theory*
In this model, interventions focus on the ongoing dynamic and complex reciprocal transactions between the child and the care-giving environment, over time. The implementation is generally custom-made for each family, and a problem-solving approach allows parents to develop skills to assess the needs of their child and family.

3.13 *Support/family self - sufficiency and empowerment*
Supportive interventions have their roots in social work and nursing. It is assumed that families are more capable of supporting themselves when they, in turn, receive adequate support. Parental social support may have indirect effects on children's behavioural development through its effect on parenting, such as improving responsivity and positive affect (shown in both high- and low-risk populations), and by improving the home environment. Mothers are assisted in gaining access to community resources, such as housing, work or child care, or support, through counselling, social skills training, or participation in a self-help group.

3.14 *Ecological theory*
Child maltreatment and difficulties in the infant are influenced not only by forces at work in the individual, but also in the family, in the community, and in the culture in which the individual is embedded (Belsky, 1993). This model emphasises connecting women to formal and informal services, and usually involves home visiting and linkage to a range of community resources.

The aims of prevention and early intervention in child mental health

4.1 In the light of our increased knowledge concerning risk and protective factors for psychosocial development, these factors - rather than short term maladaptive behavioural outcomes – should be considered as the appropriate targets for preventive interventions. Models which emerge from research into risk and protective factors have tended to be quite complex and neither

specific nor linear. For example, amongst the non-specific child outcomes of maternal depression are insecure attachment, language and cognitive problems, and social-interactive problems, as well as increased incidence of depression. Human development is characterised by a relative lack of differentiation at its early stages, considerable plasticity (at least over the first years), the availability of alternative paths to achieve the same developmental goal, and significant contextual effects. The work of Rutter (1987) has demonstrated that risk conditions occur simultaneously and the number rather than the type of risk factors are predictive of outcome. This is true for a wide range of outcomes including secure attachment, social competence and behavioural problems. Thus, in order for convincing outcomes to be demonstrated, interventions must be sufficiently long term to allow them to make an impact on multiple developmental pathways as they emerge in the midst of varying biological and environmental situations.

Key targets for preventive interventions

Fonagy (2004) lists key targets for preventive interventions as:

4.2 *Reducing the risks experienced by low birth-weight infants*
Low birth-weight infants (2,500g or less) represent 7% of newborns in industrialised countries, and very low birth-weight infants (1,500g or less) make up 1% of births. Among the associated risks are low IQ, behavioural problems and low academic attainment correlated with low socio-economic status, and maternal health behaviour problems (such as smoking). Three types of preventive interventions have been evaluated: child-focused interventions with sensory enrichment and tactile and kinaesthetic stimulation; parent-focused interventions which aim to help socially disadvantaged parents understand and meet the needs of biologically vulnerable children; and multi-systemic parent and child focused interventions that encompass the child's need for stimulation, the parents' needs for training and support and the parent-child couple's need to develop a secure relationship.

4.3 Evaluation shows that developmental delay in low birth weight infants can be prevented to some degree, most obviously in the area of cognitive development. Long term data are scarce, but multi-systemic programmes with this high risk group appear to have a positive effect on the infant's psychosocial development, although they show diminishing improvements as a child reaches school age. However, in one study at least, parent training appeared to increase rather than decrease the cognitive development benefits with age (Achenbach et al, 1990; Achenbach et al, 1993). Infants most likely to benefit in the long term appear to be those who are heavier to start with (2,000g plus), have no neurological impairments, come from poorer families, and engage well with the programme.

4.4 *Reducing the risk of cognitive delay with social disadvantage*
The prevalence of mild intellectual disability in groups with low socio-economic status is 10%, compared with 2-3% in higher groups. Attempts to

reduce this disadvantage are of four main types: home visiting aimed at helping socially disadvantaged parents understand their children's needs for intellectual stimulation, secure attachment and consistent supervision; nursery or pre-school programmes aimed at compensating for an intellectually impoverished home environment; combined home visiting and pre-school interventions; and multi-systemic programmes that provide extended services for children and families from infancy into middle childhood.

4.5 Multi-systemic programmes have been shown to be the most effective. Home visiting and combined home visiting and pre-school programmes are somewhat more effective than pre-school programmes alone, indicating the importance of family involvement. Longer programmes are far more effective than short programmes. Across studies of early intervention programmes, the following conclusions can be
drawn:

- The more comprehensive a programme, the more likely it is to be effective.
- The more attention an individual child receives, the greater the likelihood of positive effects. Thus small child-teacher ratios produce better outcomes and so do more intensive interventions.
- Interventions that begin early, including those beginning in late pregnancy, are likely to have better effects.
- The impact of short-term programmes rapidly dissipates.
- Programmes that involve the children's families are more likely to be effective.
- Programmes that include maintenance components are more effective.
- Manualised structured programmes are more effective than unstructured ones.
- If staff are rigorously supervised they are more likely to be effective.

4.6 *Prevention of physical abuse*
The risks of the physical maltreatment of children to mental health and healthy development are well established. Preventive interventions aim to reduce stress on parents, increase support, enhance parenting knowledge and skills, and promote the health of the child so as to reduce the demands children place on vulnerable parents. The programmes entail home visiting, behavioural parent training, life skills training, stress management training, and the provision of paediatric and other health care for children.

4.7 All these programmes have been shown to modify risk factors for child abuse or reduce the risk of physical abuse or both. Home visiting programmes, particularly those beginning before the birth of the child, may be particularly effective, although they do not influence parents' self-reported wellbeing. Stress management training and behavioural parent training programmes bring about marked improvements in parental wellbeing, but these appear not to be maintained at follow-up. Multi-modal community-based programmes appear to combine the advantages of home visiting and behavioural parent training, and also have low drop-out rates. Thus programmes conducted on a group basis in community centres show greatest potential in the prevention of physical child abuse.

4.8 *Parenting interventions in divorced families*
Parents' divorce is associated with increased risk of academic, externalizing, and internalizing problems in their children. Recently, a behaviourally oriented, group parent-training programme has been shown to produce a significant increase in positive parenting among divorcing mothers with sons, which accounted for improvements in the adjustment of the children as reported by teachers, mothers and the children themselves. Similarly, a programme of group and individual sessions with divorced mothers, to address support for non-custodial, non-parent adults, contact with the non-custodial parent and the quality of the custodial parent-child relationship was shown to benefit all participants, but mostly those who were at highest risk. There was a significant reduction in child behaviour problems. Improved quality of the mother-child relationship accounted for 43% of the positive outcome on the child in terms of reduction of the children's difficulties.

4.9 *Violence prevention*
There have been two distinct approaches to preventing conduct problems in childhood. The universal approach has been directed at a total population, typically of a school, to promote the development of social and emotional competence; also to address teacher behaviour and school atmosphere. The second approach has been to identify young children at risk on the basis of what is known about the developmental pathway of conduct problems. Prevention trials have employed both child focused and parent training components.

4.10 Violence prevention programmes have mainly concentrated on high-risk groups, based on the knowledge that within most communities, the 10% of adolescents who exhibit violence account for as much as 70% of violent acts. Prevention programmes guided by identifying the most high-risk groups may not always have the greatest public health benefit in reducing the problem outcome. The strategies that have offered strongest evidence of violence prevention have been universal, family-based early interventions. From present studies so far, we do not know the relative impact of universal interventions with high and low-risk young people, or selective interventions with those at high risk relative to universal ones for low-risk young people.

<u>Strategies across risk targets</u>

4.11 An alternative way of looking at the effectiveness of preventive interventions is in terms of the general preventive strategy used across a number of different risk targets. Professor Fonagy considers four types of intervention: relation-based early family interventions; attachment-focused interventions; parent training; and early childhood emotion education interventions.

4.12 *Relation-based family interventions* are amongst the most effective early interventions, which underscores the importance of the family for child development. A good example of robust gains comes from the 15-year

follow-up of the Elmeira Project where nurse visiting with low socioeconomic, status, unmarried mothers led to them making fewer social services claims and having fewer arrests and convictions than those who were not visited (Olds et al, 1997). Mothers participating in similar programmes appear to create more facilitative environments and make better use of community supports. In the UCLA Family Development Project (Heinicke and Ponce, 1999), the provision of a trustworthy relationship is assumed to improve the mother's functioning and her relationship with her family of origin, her partner and her child. The intervention was manualised and delivered by trained professionals. There were multiple benefits to a group of high-risk mothers: increased support from the family of origin, less coercion in disciplining, higher prevalence of attachment security in the child, and greater autonomy in problem-solving tasks. In particular, disorganised attachment was reduced by almost two-thirds. There were further benefits at two years in terms of the mothers' sensitivity, support of the child's autonomy and task involvement, and the child's attachment security and task orientation. Evidence suggests that for relation-based preventative intervention to be effective, multiple systems that interface with the family need to be engaged.

4.13 Among substance abusing mothers, a group who were offered supportive psychotherapy with an interpersonal relational focus showed fewer problems in many areas than a group who did not receive this intervention. At six months post-treatment, they continued to be at a relative advantage, although the magnitude of the group differences was often attenuated.

4.14 *Attachment-based interventions*
Insecure and even (the more serious) disorganised attachment are not uncommon, even in populations not considered at high risk. However, a range of adverse outcomes are not commonly found in association with secure attachment, which may therefore indicate that this is a protective mechanism and may be a legitimate conceptual framework upon which to base prevention intervention. It appears that even depressed parents can readily be helped to be more sensitive and less intrusive with their infants. Improvements in sensitivity appear to engender secure attachment. A brief three-session sensitivity-focused intervention can treble the number of infants assessed as securely attached, and this difference is maintained to 42 months (van den Boom, 1994, 1995).

4.15 Two other programmes involving mothers with depression have been shown to have an impact on early attachment relationships. The Mount Hope Family Center Program provides corrective emotional experience for depressed mothers to address distortions in the mother's perception of the child and thereby foster resilience in the infant. The programme substantially reduced the number of insecurely attached infants, so that the group of depressed mothers was comparable to a non-depressed control group which was maintained on follow-up when the children were four years old (Toth et al, 2002). A second comparative trial aimed at preventing the adverse consequences associated with maternal depression contrasted three brief interventions: a cognitive behavioural intervention; a psychodynamic psychotherapeutic protocol; and non-directive counselling (Cooper et al,

2003). Compared with the control, all three treatments had a significant impact at 4.5 months on maternal mood. However, only psychodynamic therapy produced a rate of reduction in depression significantly superior to that of the control. The benefit of treatment was no longer apparent by nine months after the baby's birth. All three treatments had a significant benefit on maternal reports of early difficulties in relationships with the infants; counselling gave better infant emotional and behaviour ratings at 18 months and more sensitive early mother-infant reactions. The treatments had no significant impact on maternal management of early infant behaviour problems, security of infant-mother attachment, infant cognitive development or any child outcome at five years. Early intervention was of short-term benefit to the mother-child relationship and infant behaviour problems. More prolonged intervention may be needed for more lasting effects, or post-partum depression may not be an efficient target for improving child mental health (McLennan and Offord, 2002).

4.16 *Parent training,* such as in Webster-Stratton programmes (Webster-Stratton, 1998), has grown out of treatment work with families with oppositionally defiant children. In general, parent training programmes have been of limited effectiveness in the prevention context because of substantial problems of client engagement. This problem is less evident when, atypically, parents who are concerned about their child are specifically recruited by advertisement (Scott et al, 2001).

4.17 *Emotion education programmes*
A number of programmes have offered affective education to very young children with the aim of increasing their awareness and expression of feelings and their ability to better understand the complex psychological causes of interpersonal behaviour (Fonagy and Target, 1997). Dysfunctions of processing emotion information have been implicated in both internalising and externalising psychological problems. However, a significant number of research trials have demonstrated that affective education, which attempts to increase children's awareness and expression of feelings and their ability to understand the possible causes of behaviour, is quite effective in the reduction of behavioural problems, as well as in the enhancement of competencies.

4.18 Carol Izard and colleagues (2002) suggest a prevention strategy for the first years of life based on practising free play with the infant which involves positive emotional expression. This is expected to help the infant acquire the ability to participate in more effective interactions with others. There is evidence to suggest that increasing the frequency of positive emotion experiences has beneficial effects on mental and physical health. Izard suggests a targeted emotion-centred intervention to facilitate the induction of positive emotion and the modulation of negative emotions. The third to fifth year of life may be a particularly sensitive period for developing a dependable foundation for accurate perception and labelling of emotions in self and others. Maladaptive emotion-cognition connections in this period probably contribute to and sustain misperceptions and misattribution that generate poor child-parent and child-peer relations in subsequent years. The labelling of

emotions, for example, represents a simple emotion-cognitive structure which may be facilitated by emotion recognition and labelling tasks, or the interactive reading of emotion stories may encourage labelling, articulation and increase the child's ability to understand the causes and functions of emotions. Emotion education also facilitates the development of empathy and socio-moral behaviour in the latter half of pre-school years (Hoffman, 2000).

What is effective?

5.1 Professor Barnes concludes that, overall, parent-as-teacher/developmental approaches are likely to have more impact on children's social competence and adaptation, while interactional and transactional methods are likely to have a greater impact on maternal reponsiveness. Models that highlight enjoyment and mutual pleasure and those that work from an empowerment perspective may be particularly effective with at-risk families. Vulnerable families are often hard to reach, and brief psychotherapy that is problem-focused and non-intrusive can be successful, as it gives more opportunity for engaging young, resistant or developmentally delayed parents. Family support programmes, (e.g. Home Start) are also perceived as relevant to vulnerable parents, in that they emphasise strengths within the family – an important avenue for engaging them.

5.2 Most approaches have many common elements. The specific theoretical underpinnings may be less important than the behaviour of the intervener. If they are able to engage with the parent and establish a shared perspective, agreeing that intervention is necessary, they are likely to be able to enhance parental and infant outcomes. In general, caring and protective relationships are potent protective factors against adverse outcomes. "To hug is to buffer", and this conclusion applies as much at the level of society and community intervention as it does at the level of families and individuals.

5.3 Whatever the theoretical background, strategies need to be flexible, taking account of family perspectives, the severity of the problem, and the environmental context. It is also important to address not only the overt parental behaviour but the associated underlying attitudes and beliefs.

5.4 The question of the relative effectiveness of one treatment when pitted against another is far less relevant than the potential value of combining modes of intervention (Kazdin, in press). To achieve lasting impact with high-risk infants and parents, no single approach will have all the answers-multi-disciplinary strategies are needed. The heterogeneity within an approach (such as psychodynamic) may be as great or even greater than the difference between one conceptual model and another. No approach has emerged as superior to other approaches. The result of reviews of outcome can be better phrased as a question rather than as an answer: how can approaches be combined to maximise effectiveness? There is much in the findings reviewed to recommend combining treatment approaches (e.g. the limited effects of

individual treatments, the multiple determinants of most disorders, the high prevalence of multiple problems). But identifying what combinations of treatments administered to which groups maximises efficacy requires further investigation.

5.5 Most professional trainings are inconsistent with this pragmatic approach. They are frequently model-based. Most professionals have inadequate training in treatments of demonstrated efficacy.

5.6 A wide variety of statutory and non-statutory organisations and professionals may be involved in preventive interventions. Almost all those who have contact with children and young people have an impact on their mental health. It follows that the most effective agents for preventing mental health problems will not be mental health professionals; nevertheless, mental health professionals may be best placed to guide this enterprise.

5.7 There is much less outcome research on secondary, as compared to primary prevention. What evidence there is suggests some benefit, particularly from those programmes that provide a combination of components. However, in general, the findings suggest that programme effectiveness could be improved by moving the intervention to an even earlier phase of the child's life.

In summary:

6.1 Primary prevention

- The earlier in the child's life the prevention commences, the more likely it is to be effective.

- Prevention needs to be disorder, context and objective specific. Focused, highly structured, proactive programmes targeting risk factors rather than problem behaviours are more efficacious than generic unstructured ones, such as the provision of counselling or group discussion.

- Multiple component, multi-year programmes which focus on a range of risk factors using a range of strategies are more likely to be effective. Similarly, programmes which simultaneously focus on the system or context within which the child lives (e.g. school, family, community), as well as on the child, are more likely to be successful than programmes which focus on the child alone.

- Prevention programmes focused on first-time mothers are particularly effective because of the acute need of these women for social support and child-rearing assistance. Programmes are effective in reducing problems and enhancing competencies.

- Only a minority of transition programmes for first-time mothers are effective, but those which are have important and widespread benefits,

including significant fiscal ones. Home visitation by itself is of little benefit without an accompanying structured programme of proven effectiveness. Many questions concerning why certain programmes are effective and others are not remain unanswered.

- The Infant Health and Development Programme (Berlin et al, 1998) for low birthweight babies showed benefits from a year of home visits, educational programmes and parent group meetings on child IQ and behaviour, but long-term benefit was limited. This and other studies indicate that the simple provision of educational and supportive input from health visitors does not benefit disadvantaged mothers in the long term.

- The Elmeira Project was more comprehensive and included formal training and parenting techniques beginning before the birth of the child and lasting for two years. Significant (32%) reductions in Emergency Room visits and child abuse (from 19% to 4%) were reported by the second year, with more positive parenting by the third and fourth year, lasting IQ gains and significant cost offset in terms of health care and assistance costs. A 15-year follow-up showed a 50% reduction in verified report of child neglect and abuse, benefit being specific to the socio-economic status group (Olds et al, 1997).

- The probable effective agent of these programmes is the fostering of a positive affectionate relationship between the mother and the infant and in the strengthening of the mothers' self-perceived efficacy in relation to her parenting role. Long term success was associated with structural change in the mother's life, particularly a delay in second pregnancy, and the provision and good take-up of pre-school facilities.

- In view of the significant long-term effect of insecure attachment on child development, and the importance of the exercise of sensitivity by the caregiver in engendering secure attachment, the enhancing of sensitivity may be an appropriate target for prevention. Programmes targeting the modification of the type of attachment in high-risk groups show promise.

- The Perry Preschool Project (Schweinhart et al, 1985), which provided a well-designed pre-school experience as well as structured home visits to promote parent-child interaction, led to superior performance, higher employment rates, and greater earning potential, as well as a reduction in arrests and incarcerations. Other relatively well-controlled trials confirm that multi-year, multi-component programmes, combining early education with family support, are a relatively inexpensive and effective way of preventing serious adolescent behavioural problems.

- Brief group interventions for children whose parents are undergoing divorce are moderately helpful and probably work by improving the quality of mother-child relationships.

- Interventions with parents are more likely to be effective, but most statutory programmes are overly didactic and pay inadequate attention to enhancing

parental competence.

- There is good evidence that extended home visitation reduces the risk of physical maltreatment and neglect in high risk groups (low socio-economic status young single mothers). Evidence for the prevention of sexual abuse is less compelling.

- Individuals at high risk of physically abusing or neglecting their child can be readily targeted, appear to be willing to take part in such programmes, and programmes that enhance parent competence are effective.

- A large number of mental health promotion programmes focusing on teaching interpersonal problem-solving have been carried out, but appear to be only moderately effective in ameliorating problems. By contrast, interventions which promote individuals' capacities for awareness of feelings and the causes and consequences of behaviour improve competence related to both of these and successfully reduce problems. They are particularly effective for younger children, as they are in the process of developing their capacities in emotion regulation and social cognition.

- There is good evidence that effective programmes have in common the following features:
  - *Comprehensiveness* – Successful programmes include multiple components because no single programme component can prevent multiple high risk behaviour.
  - *System orientation* – Interventions should be aimed at changing institutional environments as well as individuals.
  - *Relatively high intensity and long duration* – Successful programmes are rarely brief. Short-term programmes have, at best, time-limited benefits, especially with at-risk groups. Multi-year programmes tend to have an impact on more risk factors and have more lasting effects.
  - *Structured curriculum* – There is no clear indication as to the 'ideal curriculum' for preventive interventions, but proactive interventions should be directed at risk and protective factors rather than problem behaviours. In this way,multiple adverse outcomes may be addressed within a single programme.
  - *Early commencement* – This has been shown to be essential, and intervention during pregnancy brings additional benefits.
  - *Specific to particular risk factors* – It is unrealistic to hope that a generic preventive intervention will be able to reduce the risk for all psychological disorders. Prevention needs to be disorder, context and objective specific.
  - *Specific training* – There is less consistency in the literature on the qualifications required to carry out preventive work. Most studies in the UK use health visitors who have a statutory obligation to visit young children and their carers.
  - *Attention to maintaining attendance* – Those families most in need of early prevention programmes are likely to need high levels of support to engage in an intervention, and continued assistance to maintain attendance. In experimental programmes, they are the most likely to drop out.

6.2 Approaches which are based on a single conceptual model, however broad, can no longer be considered tenable: because they tend to highlight only one or two of the multiple determinants which are now known to operate in the causation of psychological disorders in children and they cannot provide adequate accounts of the complex developmental paths (vulnerabilities, risk factors and the absence of protective influences) which combine ultimately to bring about mental disorder.

6.3 Secondary prevention

- The vast majority of early intervention programmes that have been evaluated have taken place in school.

- Studies using behavioural or cognitive-behavioural interventions report higher effect sizes.

- Programmes targeting maltreating parents appear to benefit parents' overall functioning more than showing demonstrable success in preventing maltreatment. Multi-component programmes are most likely to produce significant improvements.

- There is suggestive evidence for the effectiveness of therapeutic pre-school programmes for children referred because of maltreatment, although these studies all suffer from methodological weaknesses.

- Conduct disorder is common and resistant to treatment, but there are good models of pathology and some preliminary indication that prevention is effective. However, its early identification is not entirely straightforward. Screening for externalising disorders in combination with other risk factors improves predictive accuracy, but is expensive. Programmes are most likely to be cost-effective in contexts where prevalence is high.

- Early prevention studies have targeted problem-solving skills, strengthening bonds to the school and family, and developing a positive school culture; in general, these studies have been promising, although methodological problems limit the transferability of these findings. Results from the Montreal Parent Training Prevention Trial (Tremblay et al, 1996) show equivocal results at long-term follow-up, but positive outcomes in terms of substance use, friends arrested and gang involvement were still evident at age 15.

- The Conduct Problems Prevention Research Group study is offering a long-term intensive intervention (across the first ten years of schooling) the 10% of children with early signs of conduct disturbance in kindergarten found to be at highest risk..The interventions are deliberately generalised across home and school. Early results are encouraging, although the effects are modest in relation to the comprehensiveness and cost of intervention.

Implications for Sure Start programmes

7.1 Sure Start programmes are in a unique position to carry out prevention and early intervention in child and adolescent mental health problems and disorders, in line with the evidence for what works. They also have the opportunity to provide research evidence of the effectiveness of a range of interventions with disadvantaged populations.

Work with communities at high risk of mental health problems – understanding the needs

7.2 Sure Start programmes are located in the most disadvantaged communities in England, with characteristics associated with the highest levels of risk for these problems (Wallace et al, 1997 – see Appendix). Higher rates of mental health problems and disorders are consistently reported in disadvantaged communities, as found in the inner city, but also in rural areas (chapter on Epidemiology. in: Fonagy et al, 2002). In a recent study, the mental health needs of children in a deprived area of inner London were described, encompassing risk factors as well as manifest problems (Davis et al, 2000).

Based on home interviews with mothers and children, over 85% of the sample had at least one risk factor for child mental health problems, and over 51% had three or more. The most common risk factors included maternal and paternal mental health problems; environmental problems in relation to housing and neighbours; social isolation; chronic physical health problems in the parents; and trouble with the police. Nearly 72% of the children were found to have at least one moderate to severe problem, and nearly 37% had three or more. The most frequent difficulties were: disruptive behaviour, tantrums and eating problems in the 0–4 year-olds; anxiety, persistent lying, depressed mood, temper control, and defiance in the 5–10s; temper control, depressed mood, defiance, food faddiness/eating problems, and father relationship problems in the 11-13s; and crime, school discipline problems, multiple sexual relationships, lying, high smoking/alcohol use, truancy, somatic anxiety, sleep problems, mood swings, temper control, and drug use in the 14–16s. The number of problems per child was significantly correlated with the number of risk factors.

7.3 Furthermore, in the UK national survey (Meltzer et al, 2000), a strong association was found separately between social class and family income, and the mental health of the child.

Children from families in social class V (unskilled occupations) were three times more likely to have a mental health problem than those from social class I (professionals). The prevalence of any mental disorder ranged from

16% among children living in families with a gross weekly household income of under £100 to 9% among children of families in the £300-399 weekly income bracket, and to around 6% in those families earning £500 per week or more.

Engagement of hard-to-reach families in intervention

7.4 Probably the most important role in prevention for Sure Start programmes is that they are designed to identify, among the vulnerable, the *most* vulnerable, such as teenage mothers, unsupported lone parents, mothers with mental illness, babies born prematurely and/or of low birth-weight, children with antisocial behaviour problems, and families where there is domestic violence and/or child maltreatment.

7.5 Sure Start can uniquely focus on engaging mothers and families which are traditionally hard to reach. This is particularly important in obtaining the positive outcomes shown from intensive supportive home visiting in high-risk populations. Good outcomes are not found in similar interventions, such as Webster-Stratton programmes, if there is poor engagement and a significant drop-out rate (Scott et al, 2001). Work with families starting during pregnancy appears to be particularly effective (Kitzman et al, 1997; Olds et al, 1986). Thus Sure Start programmes provide two essential elements of effective early intervention: prevention of infant problems while containing and treating existing parental problems, and providing a means of establishing positive relationships between families and service providers in the community.

7.6 Sure Start programmes can offer a flexible approach, depending on the family's circumstances. The maintenance of confidentiality is often an important consideration, but work carried out in the home setting can help to overcome a family's poor motivation and/or lack of resources. An essential component is the establishment for the mother/child/family of a trusting relationship with those who are delivering the intervention. Because Sure Start programmes are embedded within their communities, they are well placed to establish these kinds of relationships and the continuity of care which supports them. For this to work well, it is important that the whole Sure Start team understands and works towards the Sure Start target for personal, social and emotional development. The target will not be met if it is seen solely as the remit of one component of the Sure Start programme: the maternity or health visiting services, for example.

7.7 Perceptual barriers (what does this programme have to do with me?) and structural ones (how do I get to the community centre?) are relevant in the engagement of families in prevention programmes. The basis of the way in which Sure Start programmes work fundamentally addresses these issues. First is the emphasis given to consultation with parents and community members to find out the kinds of services they see as most needed and helpful and the ways in which they can most readily gain access. Second is that having set up programmes and activities that have been asked for, and used, by parents, Sure Start can then work to understand in more depth and

detail parents' mental health needs of parents and their children, and also help them to understand these and to seek appropriate help. Third, Sure Start programmes can introduce known effective intervention components in a non-threatening way into services that are well liked by parents, such as baby massage. Incentives such as payment may bring short-term results but vulnerable families are more likely to keep attending if they are allowed to discuss urgent basic needs, such as housing and food or preoccupying concerns, such as job stress, personal worries or health problems, in addition to child management difficulties.

7.8 Some of the most telling evidence is for the link between effectiveness and the style of therapeutic approach and service delivery (Bickman, 1996b; Davis and Spurr, 1998). Particularly in prevention, a didactic approach has been demonstrated to be less successful than one focused on relationship building, treating the mother as the person with responsibility to promote the development of her child (Barnard et al, 1985 cited in Fonagy, 1998). This approach is the foundation of an innovative community child and family mental health service in a part of inner London (Davis et al, 2000). Existing staff (mostly health visitors and community paediatricians) have been trained to work as parent advisers in a style characterised as having 'unconditional regard' for their clients. Evaluation has shown very high satisfaction among those who use the service, but the take-up is disappointingly low (Davis et al, 1998). Further development and evaluation of this service is focusing on matters related to the engagement of families with the service (Attride-Stirling et al, 2001).

A whole-community approach

7.9 Given that Sure Start works in communities that are defined as the most disadvantaged in the country, these communities may benefit from universal preventive programmes, thus minimising stigma. However, this may not prove to be cost effective. Research comparisons of outcomes between low- and high-risk groups offered the same intervention are few and far between. However, brief,developmentally focused interventions, such as the Neonatal Behavioural Assessment Scale (NBAS), have been shown to be effective and could prevent some early problems in parent-child relationships for all families. The NBAS is relatively inexpensive and could well be made routinely and universally available to mothers before they leave hospital with their new baby. However, in high-risk families, the impact may be short-lived unless they are provided with additional ongoing support.

7.10 While broad-based programmes appear to be more effective, there are major examples which suggest that programmes that attempt to do it all end up spreading resources thinly and achieving little. For example, the effectiveness of many popular and well-disseminated programmes, such as parenting books, has not yet been demonstrated, and the easiest interventions are usually the least effective. Educational approaches tend to have no discernable impact. Parent education and parent support programmes, in general, are far less effective than structured, skill-based approaches that are a great deal harder to implement. A number of

approaches are likely to create more problems than they solve. For example, models based solely on providing information tend to create demand for assistance without providing services that meet this demand. And it is less well known that child-focused work without addressing family problems may lead to improvement in the child at the cost of deterioration of family function. A range of services is needed to achieve optimal outcomes, to work with children, parents, parent-child pairs and family groups.

A whole-service system approach

7.11 The generality of universal preventive approaches may lead many to see them as of little relevance to themselves. It may be very difficult to modulate a programme so that it is perceived to be of equal relevance to all groups (McGuire and Earls, 1991). This is a difficult issue in implementing comprehensive programmes, as these will depend upon close integration of the work of the Sure Start programme with local mainstream provision for the same and neighbouring communities. Multi-component and multi-modal intervention depends on whole local service systems working together in concert. Therefore both mainstream services and the Sure Start programme must be signed up to common objectives and the known effective methods of working, particularly in engaging vulnerable and hard-to-reach families and providing ongoing continuity of care.

7.12 It cannot be assumed that an integrated multi-agency service system will produce good outcomes for the child and family – at least in conventional terms. The comprehensive evaluation of such a system in the US – the Fort Bragg study - showed no difference from usual traditional service provision in changes in children's symptoms and greater cost of the service, although parental satisfaction was a good deal higher among those receiving the integrated multi-agency service (Bickman et al, 1996a). The evaluators are now investigating whether the appropriateness and efficacy of the interventions actually received by children and families - as well as the style with which they are delivered - count for more in terms of service effectiveness than an integrated multi-agency response per se.

Intensity and duration of interventions

7.13 Programmes with weekly sessions, lasting from a couple of months up to a year, seem to result in greater outcome benefits than very brief interventions (which do, however, show benefit in low-risk populations). But if a reasonably satisfying therapeutic relationship cannot be established between intervener and client, then the duration or intensity of an intervention programme may be of little consequence. The same applies if the intervention model fails to meet the parent's needs; if the parent is not involved in the decision-making or disagrees with any prescribed programmes goals or outcomes.

7.14 Long term programmes (lasting from one to five years or more) can be

effective, particularly for promoting cognitive and academic progress. Again, this requires integration of Sure Start interventions with mainstream services. However, it remains to be seen from current research whether these programmes justify their expense in terms of mental health outcomes (Conduct Problems Prevention Research Group, 2002).

The role of professionals and lay workers

7.15 To achieve substantial improvements in parenting, professional involvement is likely to be needed, perhaps for the assessment of complex needs and for effective group work. However, there is little consistency in the literature on the qualifications required to perform preventive work. Most studies in the UK use health visitors who have a statutory obligation to visit young children and their mothers. A number of projects have attempted to improve the training and supervision of health visitors; for example, by providing extra didactic seminars, back-up consultation, support groups and joint case work, as well as a combination of didactic, supervisory and mutual support case discussion activities. Barker and Anderson (1988) developed a unique package in Bristol for health visitors, which sensitises them to mental health and social problems and trains them to promote the mother's self-esteem and to deliver structured interviews designed to elicit parenting difficulties. There is some evidence which tells of the success of this programme and it has been adopted quite widely in the UK. But some studies have found there was no difference in outcomes between well trained lay home visitors and professionals (Cox et al, 1993). The greatest strength of lay workers may be in improving maternal emotional state, but not specific parenting behaviours. Most families, particularly the most vulnerable, are likely to benefit from lay workers and professionals working together in planning and delivering services; both need appropriate ongoing supervision, support (the work has been noted as emotionally exhausting) and training opportunities; for example, in dealing with specific infant care problems such as excessive crying or sleep disturbance.

In conclusion

7.16 There appear to be a number of necessary, but not sufficient, factors associated with programmes that are effective in enhancing infant mental health and family outcomes (adapted from Barnes, 2003). These must inform the work of Sure Start programmes. Primary factors work in an all-or-nothing manner, predominantly related to engagement of the family in intervention and based on their perceptions and beliefs about its potential benefits:

- Shared decision-making between the parent and therapist/intervener
- Trust and respect in the relationship between parent and intervener
- Non-stigmatising presentation of the intervention
- Cultural awareness and sensitivity in planning and delivering interventions
- Crisis and practical help prior to, or alongside, other forms of intervention

7.17 If these are not addressed, it will be difficult to achieve changes in behaviour. Fine-tuning of the intervention can then be decided upon according to specific circumstances, in terms of:

- Choice of theoretical model
- Choice of intensity and duration of intervention
- Choice of timing/location – during working or out-of-work hours/home, clinic, community venue
- Choice of intervener – professional, paraprofessional

7.18 Effective intervention for the promotion of child mental health requires that appropriate attention be given to both the child and the mother, and to the family/carer and community contexts. In order to be effective, interventions very often also require appropriate ongoing attention from a number of agencies in the promotion of child mental health.

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APPENDIX

Prevalence of specific child and adolescent mental health risk factors and impact on rate of mental disorder

Risk factors in child	**Impact on rate of disorder**
Physical illness – chronic health problems – brain damage	 Three times increase in rate 4-8 times increase in rate of disorder in youngsters with cerebral palsy, epilepsy or other disorder above the brainstem
Sensory impairments – hearing impairment (four per 1000) – visual impairment (0.6 per 1000)	 2.5-3 times more disorder no figures but rate of disorder thought to be raised
Learning difficulties	2-3 times increase in rate, higher in severe than moderate learning difficulties
Language and related problems – 2%, but better methods of identifying required	Four times rate of disorder
Risk factors in the family	**Impact on rate of disorder**
Family breakdown divorce affects one in four children under 16 years of age severe marital discord	Associated with a significant increase in disorders e.g. depression and anxiety
Family size	Large family size associated with increased rate of conduct disorder and delinquency in boys
Parental mental illness – schizophrenia – maternal psychiatric disorder	 8 to 10 times rate of schizophrenia 1.2 to 4 times the rate of disorder
Parental criminality	2 to 3 times rate of delinquency
Physical and emotional abuse – of those in child protection registers, one in four suffer physical abuse and one in eight neglect	Twice rate of disorder if physically abused and thrice if neglected
Sexual abuse – 6-62% in girls and 3-31% in boys	Twice rate of disorder if sexually abused
Environmental risk factors	**Impact on rate of disorder**
Socio-economic circumstances	
Unemployment	
Housing and homelessness	
School environment	9% in grades one to nine are victims of bullying 7-8% of children have self-reported bullying of other children
Life events	**Impact on rate of disorder**
Traumatic events	3 to 5 times rate of disorder. Rises with recurrent adversities

(Wallace et al, 1997)