

What works in promoting children's mental health

The evidence and the implications for Sure Start local programmes

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It is well established that the mental health of children is crucial for their healthy overall development, and that the prevention of mental health problems and disorders, and early intervention, are the most likely approach for ensuring health, well-being and social inclusion in adult life¹.

A number of systematic reviews of the literature have brought together the evidence on the effectiveness of currently available interventions in the treatment of mental health problems and disorders in children (Fonagy et al, 2002). This evidence shows that, for the most part, treatment of established disorders has limited effectiveness and is more successful in the earlier stages of manifest problems. This paper summarises what is known about the most promising approaches in prevention and early intervention.

This evidence has particular relevance for Sure Start local programmes, working as they do with parents and parents-to-be, infants and pre-school age children in the most disadvantaged communities in England. As children in these communities show the highest risk of mental health problems, it should be the basis for service planning, development and practice in all Sure Start local programmes, in particular to meet the Sure Start 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”.

This summary is largely based on two major reviews of the published literature, carried out by Professor Peter Fonagy at University College London (Fonagy, 1998; Fonagy et al, 2002; Fonagy, 2004) and Professor Jacqueline Barnes at Birkbeck College London (Barnes and Freude-Lagevardi, 2002; Barnes, 2003). The implications for Sure Start local programmes are drawn from the findings of these reviews and other studies.

While this research report is aimed at Sure Start local programmes, much of the information will be relevant to most professionals working in the delivery of services for children aged birth to six.

¹ Department of Health. Report of an Independent Inquiry into Inequalities in Health (chairman: Sir Donald Acheson). 1997, London: The Stationery Office; National Strategy for Neighbourhood Renewal. Report of Policy Action Team 12: Young people. 2000, London: TSO; Fonagy P, Target M, Cottrell D, Phillips J, Kurtz Z. What works for whom? A Critical Review of Treatments for Children and Adolescents. 2002, New York & London: Guilford.

Key findings

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.

Approaches which are based on a single conceptual model, however broad, cannot be considered tenable. This is 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 take account of the complex developmental paths (vulnerabilities, risk factors and the absence of protective influences) which ultimately combine to bring about mental disorder.

A number of factors in programmes that are effective in enhancing infant mental health and family outcomes appear to 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/intervenor.
- Trust and respect in the relationship between parent and intervenor.
- 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.

These factors must inform the work of Sure Start local programmes – if they 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 or community venue;
- choice of intervener – professional or paraprofessional.

Effective intervention for the promotion of child mental health requires appropriate attention to be given to both the child and the mother, and 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.

The importance of prevention and early intervention in the promotion of child mental health

The prevalence of disorders is high: in Great Britain, 10.4% of children aged five to 15 years old 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). The rates are higher in adolescents than in younger children. And 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%.

It is increasingly recognised that untreated emotional disorders and disruptive behavioural problems in childhood have poor long-term outcomes. In the follow-up of a UK national survey, 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. Many childhood disorders progress beyond adolescence to mental illness in adulthood, e.g. in children, conduct disorder leads in adulthood to anti-social personality disorder, while depression leads to affective disorders.

Mental health problems and disorders are strongly associated with difficulties at school, difficulties with peer relationships and poor school attainment. Difficult behaviour is the most common reason for children to be excluded from school, with a high risk of further mental health problems (Barnes, 1998). Young people in the criminal justice system are also highly vulnerable with respect to mental health problems (Kurtz et al, 1998), with particularly high rates in young persistent offenders (Hagell and Newburn, 1994).

Recent research has also shown that mental health problems in children give rise to heavy financial costs, which fall on many agencies. 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 (Scott et al, 2001).

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). For many mental disorders of childhood, treatment interventions are relatively ineffective. And 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.

Much has been learnt about risk and protective factors for almost all child mental health disorders and the basis for prevention is the ability to reduce risk or strengthen protective factors in the developmental causal chain of a disorder. This allows appropriate targeting of interventions in early childhood in the light of emerging evidence on which of these risk or protective factors can be modified by interventions.

Preventive approaches and what works

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.

Approaches to intervention

Barnes covers the following theoretical models for early intervention.

- ▶ **Parent-child bonding** aims to enhance the mother-infant relationship.
- ▶ **Psychodynamic (brief) parent-infant psychotherapy** aims to enhance reciprocity, communication and mutually shared pleasure between mother and infant.
- ▶ **Infant-led psychotherapy** aims 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.
- ▶ **Attachment theory** aims to alter the mother's view 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.
- ▶ **Developmental theory** aims to strengthen parental interest in the child and responsiveness based on understanding of the infant's capabilities and signals.
- ▶ **Pedagogical/parent as teacher** aims to increase parents' knowledge of child development and increase their competence and sense of confidence.
- ▶ **Interactional-relational guidance**, offered in the context of psychotherapy, is more individualised and flexible than developmental guidance. This approach always includes the infant and aims to modify patterns by making mothers aware of their interactive styles, emphasising harmonious interactions.
- ▶ **Transactional theory** is a problem-solving approach, focusing on the ongoing dynamic and complex reciprocal transactions between the child and the caregiving environment over time, for parents to develop skills in assessing the needs of their child and family.
- ▶ **Support/family self-sufficiency and empowerment**, with roots in social work and nursing, may have indirect effects on children's behavioural development through its effect on parenting and improving the home environment.
- ▶ **Ecological theory** usually involves home visiting and emphasises connecting women to formal and informal services, working with the family, community and cultural influences on difficulties in the infant and child maltreatment.

What works – 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 responsiveness.

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 (eg. Home Start) are also perceived as relevant to vulnerable parents in that they emphasise strengths within the family – an important avenue for engaging them.

Fonagy lists key targets for preventive interventions as:

- ▶ **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, developmental delay, behavioural problems and low academic attainment correlated with low socio-economic status, and maternal health behaviour problems (such as smoking).

What works – Developmental delay can be prevented to some degree – most obviously in the area of cognitive development – by 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.

- ▶ **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 those with higher status.

What works – Multi-systemic programmes have been shown clearly to be effective, with the following characteristics:

- 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.
 - Interventions that begin early (including 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 likely to be effective than unstructured ones.
 - If staff are rigorously supervised, they are more likely to be effective.
- ▶ **Prevention of physical abuse.** The risks of the physical maltreatment of children for mental health and healthy development are well established.

What works – Multi-modal community based programmes appear to combine the advantages of home visiting and behavioural parent training, and also have low drop-out rates.

- ▶ **Parenting interventions in divorced families.** Parents' divorce is associated with increased risk of academic, externalizing, and internalizing problems in their children.

What works – Behaviourally oriented group parent training, combined with individual sessions have been shown to improve the quality of the mother-child relationship, which accounts for over 40% of the reduction of the child's difficulties.

- ▶ **Violence prevention.** The 10% of adolescents who exhibit violence account for as much as 70% of violent acts.

What works – The strategies that have offered the strongest evidence of violence prevention have been universal, family-based interventions. Programmes (with both child-focused and parent training components) with children identified on the basis of what is known about the developmental pathway of conduct problems can also be effective, but result in less public health benefit.

What works in interventions that have an impact across risk targets

- ▶ **Relation-based family interventions** are among the most effective early interventions.
- ▶ **Attachment-based interventions** have been shown to be effective in helping depressed parents to be more sensitive and less intrusive with their infants, and thereby to engender secure attachment.
- ▶ **Parent training** such as Webster-Stratton programmes (Webster-Stratton, 1998) has grown out of treatment with oppositionally defiant children. Effectiveness depends crucially upon the full engagement of parents with the programme.
- ▶ **Emotion education programmes** which attempt to increase children's awareness and expression of feelings and their ability to understand the possible causes of behaviour have been shown to be quite effective in the reduction of behavioural problems and in the enhancement of competencies.

Most approaches have many effective elements in common

Engaging with the parent, establishing a shared perspective and agreeing that the intervention is necessary are all likely to enhance parental and infant outcomes. The specific theoretical underpinnings of an approach may be less important than establishing a rapport with parents. Whatever the theoretical background, strategies need to be flexible, taking account of the severity of the problem and the environmental context.

To achieve lasting impact with high-risk infants and parents, no single approach will have all the answers – multi-disciplinary strategies are needed. The relative effectiveness of one treatment is less relevant than the potential value of combining modes of intervention (Kazdin, in press). Identifying the appropriate combination of treatments for specific groups requires further investigation.

To achieve substantial improvements in parenting, professional involvement is likely to be needed, such as 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. And 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 – and 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, and training opportunities.

Implications for Sure Start local programmes

Sure Start local programmes are located in the most disadvantaged communities in England, with characteristics associated with the highest levels of risk for mental health problems and disorders. These communities may benefit from

Universal preventive programmes. These minimise stigma but may well prove not to be cost effective. Research comparisons of outcomes between low- and high-risk groups offered the same intervention are few and far between. Nevertheless, brief, developmentally focused interventions, such as the Neonatal Behavioural Assessment Scale (Brazelton, 1973), have been shown to be effective and could prevent some early problems in parent-child relationships for all families.

Targeted interventions. Probably the most important role in prevention for Sure Start local 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. Sure Start local programmes can offer targeted interventions on the basis of in-depth understanding of individual needs.

Engaging mothers and families. Uniquely, Sure Start can focus on engaging mothers and families which are traditionally hard to reach. For example, the positive outcomes shown from intensive supportive home visiting in high-risk populations are less impressive in similar interventions, such as Webster-Stratton programmes, if there is a significant dropout rate (Scott et al, 2001). Work with families starting during pregnancy appears to be particularly effective (Kitzman et al, 1997).

Thus Sure Start local 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.

A whole programme approach based on the Sure Start ethos accords with the evidence for good practice in the promotion of child and family mental health: consultation in development of a programme according to what the community says it needs, joint decision-making over interventions with individual families, flexibility in the timing and setting for delivery of interventions, and, most importantly, a trusted and respectful relationship between the family and those delivering the programme, with confidentiality assured.

Holistic support. Sure Start local programmes have the capacity to offer services tailored to the specific needs of individual families, such as support during financial crisis or marital problems. These situations are often seen by families as the overriding issue, but these services also offer opportunities for mental health interventions to be introduced in a non-threatening way. In this and other ways, Sure Start local programmes can address contextual factors that may impact on effective intervention for the child.

Intensity and continuity of services. Lay workers and professionals working together enable Sure Start local programmes to offer intensity and continuity in the delivery of interventions. Because Sure Start local programmes are embedded within their communities, they are in a good position to work with the whole local service system (mainstream and voluntary sector) and to ensure ongoing support where necessary.

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