

# Chapter 7: Emotional and behavioural problems

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*Childhood is not just a preparation for life, it is a part of life.*

*Notes on an Unhurried Journey, John A Taylor<sup>1</sup>*

Rates of psychiatric disorders in young people are rising.<sup>2</sup> These disorders frequently begin in childhood and are often a source of considerable distress and lost opportunities for the children involved, their families or both. Much is now known about cost-effective prevention and early intervention in the development of emotional and behavioural problems, in order to support a healthier developmental path. The challenge is to develop and implement coordinated and effective primary and secondary preventive initiatives on a widespread and equitable basis, at a time when resource constraints have led to significant reductions in spending on early intervention in the public sector.

## 7.1 Definitions of mental health

Children's mental health is not simply the absence of mental ill health, but can be described in its own right. The NHS Health Advisory Service definition<sup>3</sup> has been widely adopted.

The components of mental health include the following capacities:

- the ability to develop psychologically, emotionally, intellectually and spiritually
- the ability to initiate, develop and sustain mutually satisfying personal relationships
- the ability to become aware of others and to empathise with them
- the ability to use psychological distress as a developmental process so that it does not hinder or impair further development.

Within this broad framework, and incorporating the developmental nature of both body and mind in childhood and adolescents, mental health in young people is indicated more specifically by:

- a capacity to enter into and sustain mutually satisfying relationships
- continuing progression of psychological development
- an ability to play and learn so that attainments are appropriate for age and intellectual level
- a developing moral sense of right and wrong.

For babies and younger children, infant mental health has been defined as: 'the young child's capacity to experience, regulate and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development'.<sup>4</sup>

Infants and young children are entirely dependent on their caregivers and context to support their emotional development and mental health. There is a complex interrelationship between the child's individual characteristics, the capacity of parents to provide sensitive and developmentally appropriate care, the support and services available in the wider community, the quality of the physical environment, and the degree to which Government policy is family-friendly.

From this systemic perspective, it is apparent that a variety of agencies, both statutory and non-statutory, will have an interlinking impact on the mental health of young children. This needs to be acknowledged in planning initiatives promoting young children's mental health.

Many young children will experience an impairment in their mental health or emotional wellbeing at some point.<sup>5</sup> One study showed that the prevalence for three year old children was 10 per cent with 66 per cent of parents sampled having one or more concerns about their child.<sup>6</sup> A further study showed that 7 per cent of children aged 3-4 years exhibited serious behaviour problems.<sup>7</sup> For these children, the nature of their problems may be conceptualised in different ways. In addition to the variety of familial and cultural explanations that may be evoked for the child's difficulties, health services, education services and social services will often think about these children using different language and emphasising different aspects of their problems. These differences can breed misunderstanding and inhibit communication. Psychiatrists, for example, tend to distinguish between normal and abnormal groups of children, and think of the abnormal group as having disorders with specific characteristics, treatments and outcomes. They see these disorders as produced by an interaction of biology and environment. Teachers, and others involved in education, tend to use an undifferentiated category of 'emotional and behavioural problems'. They see these as primarily caused by adverse environmental factors, in particular problems in the family context, and perceive them as essentially amenable to improvement through education. Social workers and workers in the voluntary sector, tend to regard labelling children as a stigmatising process which is best avoided, and prefer to explain children's problems in social terms. These descriptions are of course stereotypes, and there will be many exceptions to the characterisations presented. Many GPs and health visitors, for example, often think more like teachers and social workers than typical medical professionals. But the problem of different languages and conceptual frameworks in different professional groups, and between

professionals and the families they are working with, is a real one. It inhibits the development of the common understandings and collaborative relationships which are so important across and within the different organisations involved with young children – the NHS, social services, education, and the voluntary sector – and between these agencies and the families accessing their services.

## **7.2 Identifying young children with emotional and behavioural problems**

All infants and young children will display some degree of emotional or behavioural disturbance at various stages in their development, and these relatively transient perturbations are an ordinary part of growing up. It is to be expected that a child will be stressed by the birth of a sibling or the separation involved in starting nursery, though different children will display their feelings to differing extents and in different ways.

For families whose children have more extreme or pervasive emotional or behavioural problems, or where the problems do not resolve despite their parent or carer's efforts, additional assessment or support may be needed from universal services such as health visitors, GPs or nursery staff, or possibly from psychologists or other specialist mental health professionals.

## **7.3 Common types of emotional and behavioural problems age 0 to five years**

Different sorts of emotional and behavioural problems in children aged 0 to five years need to be distinguished from each other, so that appropriate treatment and support can be provided. Persistent emotional and behavioural disturbance in young children may be an early indication of developmental problems, such as autism, speech and language disorders or learning disabilities, and professionals in contact with young children need to be able to identify children who are deviating from the expected developmental trajectory. Early identification allows the possibility of early intervention which can optimise outcomes for the child.

Sleeping problems are common in young children and can cause considerable stress for their families. Approximately 20 per cent of children aged one to three years, and 10 per cent of children aged four to five years, have significant problems settling to sleep and waking at night. Providing support for parents to modify their child's sleep pattern so that they start to sleep better can improve not only the child's sleep, but also the child's daytime behaviour and overall parent-child interactions.

Feeding problems are also common in young children, and include faddiness and selective eating and more severe problems resulting in failure to thrive.<sup>8</sup> An American review found feeding disorders in 25 per cent of children developing normally and 80 per cent of children with developmental delay.<sup>9</sup> UK data from 2009/10 found 19.7 per cent of

children entering school were obese.<sup>10</sup> Both biological and environmental aspects should always be considered in the assessment and management of feeding difficulties. More straightforward problems can be managed in primary care, but referral for specialist multidisciplinary assessment will be needed in more complex cases (see **Chapter 4** for a more detailed discussion on feeding).

Tantrums, aggression and non-compliance are part of ordinary toddler development, as young children experiment with autonomy and test parental limits, but some young children have pervasive and protracted behaviour difficulties in excess of those seen in their peers. Behaviour problems that may be seen as outside the developmental norm for this age group include frequent aggressive behaviour in the absence of prosocial behaviour, and aggressive behaviour which appears proactive rather than occurring as reaction to frustration, alongside an overall inflexibility, fearlessness and resistance to control. Approximately 50 per cent of these young children will have persistent behaviour problems and may be diagnosed with oppositional defiant disorder or conduct disorder in later childhood.<sup>11</sup>

Restless, impulsive and excitable behaviour is common in young children, though in some this behaviour may be extreme and some parents may question whether their child has ADHD. Guidelines from NICE recognise the diagnosis in children aged three years and above, where the child has persistent inattentiveness, hyperactivity and impulsiveness that is marked in relation to peers, is present in more than one setting, and causes at least moderate impairment. Diagnosis needs to be made by a specialist, and recommended UK treatment for ADHD in pre-school children is parental attendance on a structured group-based parenting programme.<sup>12</sup> These parenting programmes, which should meet criteria set out by NICE, are also recommended for parents of children with disruptive behaviour problems.

Young children who have been exposed to single or repeated traumatic experiences, either within or outside the family, may show emotional and behavioural disturbances, including distressed reactions to reminders of the traumatic events, repetitive re-enactments in their play, sleep disturbance and developmental regression.<sup>13</sup> Children under five years can be diagnosed with post-traumatic stress disorder (PTSD), though some aspects of the diagnostic criteria are not developmentally appropriate for this age group.

Many young children will be fearful and anxious at times, but most will be successfully reassured and comforted by their parent or carer. Where the child's distress is more sustained, and the parent is struggling with helping their child manage their anxieties, some professional help may be needed to support the parent-child dyad.

A few young children will have such disturbed relationships with their caregivers that they are diagnosed with attachment disorders. Most of these children will have been severely neglected or abused. They may be either extremely withdrawn and inhibited in social situations, or indiscriminately social and disinhibited. There is a distinction between children diagnosed with attachment disorders and the much larger group of children described as having insecure or disorganised attachments towards their caregivers. This latter group are at increased risk of emotional or behavioural problems but do not meet diagnostic criteria for having a disorder.

#### **7.4 Long-term consequences of mental health problems in children aged 0 to five years**

There is now good evidence that problems in the early years of childhood may presage problems in adolescence and adult life.<sup>14</sup> A New Zealand longitudinal study of mental health outcomes, showed that restless impulsive three year olds had higher rates of serious persistent antisocial behaviour at age 21, and unduly shy, inhibited three year olds had higher rates of depression at the same age. Three-year-old boys in either group, had an increased risk of alcohol-related problems at age 21, and both groups of three year olds had an increased risk of suicide during adolescence. Another review concluded that children identified as hard to manage at ages three or four years have a high probability (approximately 50:50) of continuing to show behavioural difficulties throughout primary school years and into adolescence.

This review identified the following factors as predictive of behaviour problems that persist from the early years:

- the presence of multiple behaviour difficulties (spread)
- problems evident in different contexts (pervasiveness)
- a distressed and/or dysfunctional family context.

There is also a considerable financial cost of leaving young children's behaviour problems untreated.<sup>15</sup> In one study of 80 children aged three to eight who had been referred to CAMHS with severe antisocial behaviour, it was calculated that mean additional costs of £5,960 had been incurred in one year. These costs are both incurred by the family (including time off from work because of the child's behaviour and repairs to the home following damage), and also by the additional services involved with the child because of their behaviour. Another study followed up children who had been diagnosed with oppositional defiant disorder or conduct disorder at the age of 10 years. By the age of 27, each had cost the public around £200,000, 10 times more than children in a control group.<sup>16</sup> These potentially adverse long-term costs and consequences of emotional and behavioural problems in childhood mean that these merit identification and treatment when problems first emerge. Of course, in addition to these longer-term reasons for addressing emotional and behavioural problems in

the early years, children and families also need help with these problems because of the immediate stress and distress that they cause.

## 7.5 Risk and protective factors for young children's mental health problems

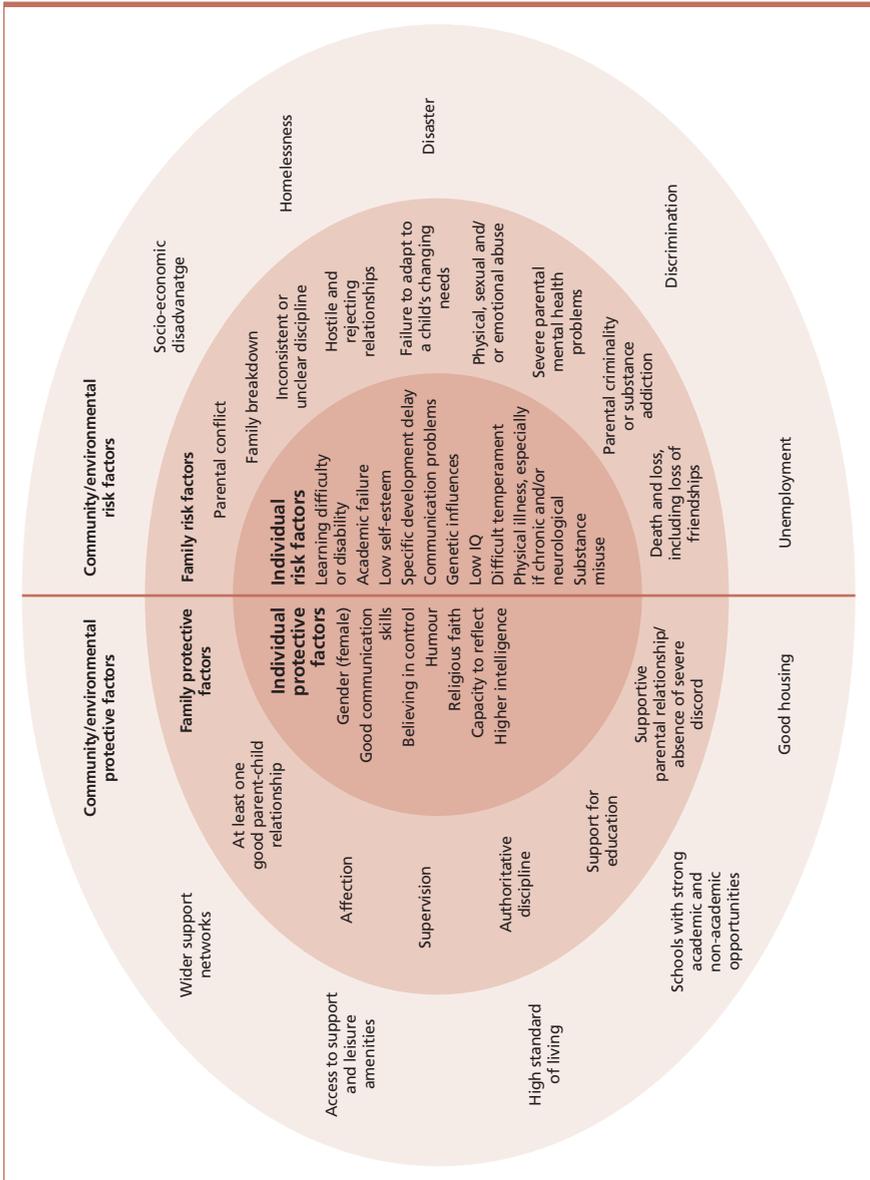
Children's mental health problems are not the product of simple chains of causality. Problems that appear similar may have arisen for very different reasons in different children. In children whose main problem is aggressive behaviour, for example, this may have a number of different causes. For some, their aggression may be linked to their individual characteristics. Children with delayed language development may hit out because their limited powers of communication leave them frustrated. For other children, family issues may be more important. Domestic violence within the family may be echoed by aggression in the children. Yet for others, social issues may have a significant impact. In families where unemployment, poor housing, and financial difficulties combine to preoccupy the adults, there may be little time and energy available for appropriate parenting. For many children with mental health problems, individual, family and social risk factors such as these will interact. In the same way that there is little specificity linking children's mental health problems with single causative factors, in general, there is also a lack of specificity between particular risk factors and particular mental health problems in children.

Single risk factors are less powerfully correlated with mental disorder in children than multiple risk factors. Having a single risk factor very slightly increases the risk of having a disorder, but with two or more risk factors, the risk of negative outcomes increases considerably.

In conceptualising causation in individual cases, it is useful to think of a balance between risk factors and protective factors. Protective factors can reduce the adverse impact of risk factors. A single mother with a low income, for example, may find the support of her extended family helps her cope with her new baby, and protects her from the normal ups and downs of new motherhood becoming chronically problematic.

**Figure 7.1** shows some of the risk and protective factors that influence children's mental health.

Figure 7.1: Risk and protective factors that influence children’s mental health



Source: Department of Health (2008) *Children and young people in mind: the final report of the National CAMHS Review*. London: Department of Health. Reproduced with permission from the Department of Health.

Interventions need to focus both on reducing risk factors and on increasing resilience. Resilience is an individual's tendency to cope with stress and adversity. Resilience can be promoted at individual, family and community levels by reducing exposure to risks and adversity, boosting the child's individual resources and the assets in their lives, and mobilising innate adaptational capabilities.

## 7.6 Individual risk factors

### Genetic factors

The old debate over whether particular mental health problems arise because of nature (genetics) or nurture (environment) has been replaced by a much more sophisticated appreciation that genes and environment act in a way that is mutually interlinked. A child's genetic inheritance may contribute a vulnerability that, in combination with environmental adversity, can result in mental health problems. Replicated findings have shown that those children who have a genetic variant which produces lower levels of monoamine oxidase A (MAOA) enzyme have higher rates of conduct disorder, antisocial personality, and criminality when exposed to physical maltreatment.<sup>17</sup> Other children, however, who also have lower levels of MAOA enzyme but who are not exposed to physical maltreatment, do not have higher rates of these problems in later life.<sup>17</sup> The gene variant producing lower levels of MAOA is only a vulnerability factor for adverse outcomes if children with this variant are also exposed to physical maltreatment. In a similar way, children with other genetic variants, in combination with adverse environmental conditions, are predisposed to later depression and suicide.

The idea that children are genetically predisposed to be more or less vulnerable to environmental stressors has been expanded to suggest that children are genetically predisposed to be more or less sensitive to environmental influence, both good and bad. This has been characterised in terms of 'daffodil' children who are genetically resilient in the face of adversity, and 'orchid' children who are genetically vulnerable to environmental adversity but also respond exceptionally well to positive aspects of their environment. One Dutch study involved an intervention to promote parental sensitivity in toddlers with high levels of behaviour problems, and studied the relative responsiveness to the intervention in children with different genetic susceptibility to behaviour problems.<sup>18</sup> The group of children with the high-risk genetic variant, who would be most vulnerable to adverse circumstances, in fact responded most positively to the supportive intervention.

In the future, interventions may be tailored to the specific genetic profile of individual children, but in the meantime, reducing adverse environments and promoting high-quality parenting are likely to reduce the numbers of children whose genetic vulnerabilities manifest in later mental health problems or other negative outcomes.

## Disability

Psychiatric disorders are two to four times as common in children with learning disabilities, with 30 to 50 per cent of them having a diagnosable mental disorder. Autism and ADHD are more common in children with learning disabilities than in children without learning disabilities. Psychiatric disorders, however, may be difficult to detect in children who have reduced verbal communication, and professionals may find it hard to distinguish between the features of the learning disability and the features of the mental disorder.

Children with physical disabilities are also at increased risk of psychiatric disorders, particularly where their disability involves brain damage. **Table 7.1** shows relevant results from an epidemiological study of 10 and 11 year olds.

**Table 7.1: Increased risk of psychiatric disorders in children with physical disabilities – results from an epidemiological study of 10 to 11 year olds**

| Children with:                              | % with psychiatric disorder |
|---|-----------------------------|
| • no physical disorder                      | 7                           |
| • physical disorder not affecting the brain | 12                          |
| • idiopathic epilepsy                       | 29                          |
| • cerebral palsy and allied disorders IQ>70 | 44                          |

Source: Goodman R & Scott S (1997) *Child psychiatry*. Oxford: Blackwell. Reproduced with the permission of Wiley-Blackwell.

Other disabilities in children have also been shown to be associated with increased rates of psychiatric disturbance, including severe hearing loss and marked language delay or impairment. The increased rates of mental health problems in children with disabilities is in some cases related to brain damage, and in others is linked to the psychosocial disadvantages experienced by some children with disability. Many children will have both a biological and psychosocial vulnerability to mental health problems. For families, it is often the behaviour problems, like chronically disturbed sleep or aggressive outbursts, which are the hardest aspects of their child's problems to deal with.

The families of the babies which have disabilities evident at birth, and also those whose children's disabilities become apparent at a later stage, need a comprehensive range of support, which may involve health, education, social and voluntary services. Improving the early detection of emotional and behavioural problems in children with disability and the effective management of these problems involves developing greater awareness of good practice and better coordination of services.

### Individual resilience

Some individual characteristics promote resilience in children. These include intrinsic qualities such as easy temperament or high IQ.<sup>19</sup> Other individual attributes such as secure attachments, positive self-image, effective interpersonal skills, cognitive skills and the development of special talents, can be nurtured through good parenting and high-quality pre-school provision.

## 7.7 Family risk and protective factors

### Family size

Children from larger families are at increased risk of mental health problems, with 13 per cent and 18 per cent of four- or five-children households respectively having mental health problems, in comparison with 8 per cent of two-children households.<sup>20</sup> Children from large families are twice as likely to develop conduct disorder and become delinquent than children from smaller families. Such children are also more likely to have delayed language development, lower verbal intelligence and lower reading attainment, and to experience less parental supervision and more sibling aggression, all of which may contribute to their behaviour problems.

### Family structure

The Millenium Cohort study has tracked almost 15,500 UK children born in the year 2000 and has examined family structure and its influence on emotional and behavioural problems at the age of five years. Children either born to mothers in cohabiting relationships where the parents had separated, or born to solo mothers who had not married the natural father, had three times as many behaviour problems in comparison to children born in stable married families.<sup>21</sup> Taking into account maternal depression and family poverty reduced the difference in the level of behaviour problems between the different types of family structure, but it remained statistically significant.<sup>21</sup> Similar levels of emotional problems were found across all types of family structure, once maternal depression and differences in income were taken into account. Children raised in families where the parents are lesbian or gay are not at increased risk of emotional or behavioural problems.

## 7.8 Parental risk factors

### Parental mental ill-health

Parental mental disorder is associated with increased rates of mental disorder in children.<sup>22</sup> This is often assumed to be because the parent's mental disorder disrupts effective parenting, but may also be because of a shared genetic vulnerability between parent and child, or because the child is exposed to many other environmental adversities such as poverty, poor housing and isolation, which are often features of life for those with chronic mental illness. The types of disorder that children develop do not correspond exactly to those experienced by their parents, though there is a tendency for young children of depressed mothers to show apparent symptoms of depression, and an

association between personality disorder in a parent and conduct disorder in children. Parents with mental illnesses may be consistently or periodically affected, and their parenting can be severely or only mildly affected.<sup>23</sup> Where they are unable to parent effectively, the effect on their children can be buffered by the presence of another adult, or the other parent, who can take on the main caregiving role as necessary, ideally with minimum disruption to the children's normal routines.

For children aged 0 to five years, one important category of parental mental illness that has been the subject of much research is postnatal depression. This affects approximately 10 per cent of mothers. Many mothers with postnatal depression find it difficult to provide sensitive and responsive care for their infants, and observational studies have shown behavioural, emotional and cognitive changes in the infants of these mothers.

Fathers may also experience some degree of depression after the birth of a child, and this has been shown to be associated with adverse emotional and behavioural outcomes in their children at the ages of three to five years, and an increased risk of conduct problems in boys.

### Parents who abuse drugs or alcohol

It is estimated that there are between 200,000 and 300,000 children in England and Wales where one or both parents have serious drug problems, and between 780,000 and 1.3 million children affected by parental alcohol problems. Drugs and alcohol can adversely affect the developing fetus.<sup>24</sup> In 2007, the BMA published a guide for healthcare professionals on fetal alcohol spectrum disorders (FASD).<sup>24</sup> The guide considered the adverse health impacts of alcohol consumption during pregnancy and the particular problem of FASD. The child's parenting and home situation may also be unstable and chaotic, leaving younger children particularly vulnerable.<sup>25</sup> Parental abuse of drugs or alcohol is associated with higher levels of behavioural and emotional problems in children.

### Parental conflict, separation and divorce

Children are at an increased risk of mental health problems where there is parental disharmony and also where parents divorce or separate, but there is considerable variation in how different children react. Divorce or separation is also often accompanied by conflict and by a reduction in economic security, and the impact of these different stressors on children's lives can be hard to disentangle. Each family situation is different and no universal recommendation can be made about whether parents in conflict should stay together or split up. Immediately after divorce or separation, children's levels of distress increase, but after a while, most children adjust to the new circumstances, and may be less stressed than children whose parents remain together in a high-conflict situation. For families facing divorce or separation, the young children will benefit from minimal disruptions to their usual routine, a simple explanation of what is happening, and reassurance that it is not their fault.

### Domestic violence

Exposure to domestic violence increases the risk of children developing emotional and behavioural problems.<sup>26</sup> Young children in particular are dependent on their parents to provide safety and security, and this is fundamentally undermined by violence in the home. Infants and young children exposed to domestic violence may be excessively irritable or distressed, regress in their language development or toilet training and have sleep disturbances or separation anxiety. Parents often underestimate the impact of any violence on the children, but a survey has found that in 90 per cent of domestic violence incidents children are in the same room or the next room. Forty to 60 per cent of children exposed to domestic violence also experience direct emotional, physical or sexual abuse themselves. Witnessing or experiencing violence as a child is associated with greater use or tolerance of violence as an adult, with an intergenerational transmission rate of about 30 per cent. The BMA's 2007 report *Domestic abuse* examines how children who are exposed to violence in the home may suffer a range of severe and lasting effects.<sup>27</sup> The BMA's report is intended to lead the way in encouraging the healthcare professions to raise awareness of the problem and makes recommendations for tackling domestic abuse.

### Parent-child interactions

It is often the quality of parenting and parent-child interactions in a family, as they tackle the normal or exceptional problems of their child's development, which differentiates between a vulnerable child who develops mental health problems and a vulnerable child who achieves his or her potential. A family's capacity to parent effectively will be intimately connected to the levels of support and stress they experience. How parents raise their children is influenced not only by how they were raised themselves and who they become, but also by the everyday circumstances of their lives, and the resources to which they have access. Statutory and voluntary services can play an important role in helping parents provide a nurturing environment for their children.

### Antenatal effects

Parenting begins before birth and the developing fetus can be affected by smoking, drugs (including alcohol), poor nutrition and excessive maternal stress or anxiety.<sup>25,28</sup> Smoking in pregnancy increases the risk of low birth weight, with its attendant problems. In 2004, the BMA published a guide for healthcare professionals on the impact of smoking on sexual, reproductive and child health in the UK.<sup>29</sup> The report considered active and passive smoking by both men and women, and summarises the impact on sexual health, conception and pregnancy, as well as effects on the reproductive system. If the developing fetus is regularly exposed to heroin, cocaine or large amounts of alcohol, a variety of adverse effects have been reported, including short and long-term difficulties with modulating arousal, activity level and attention. These deficits can make parenting difficult, and where the parent is still involved in substance misuse, they may already have reduced resources for the task of parenting. Pregnancy may, however, act

as a trigger for behavioural change, inspired by concern for the developing fetus. Advice, sensitively given, may help pregnant mothers reduce their alcohol intake, stop smoking, and stop using other drugs.

Excessive maternal stress and anxiety have also been shown to be linked with emotional and behavioural problems in the fetus, with the children of the most anxious 15 per cent of mothers having double the risk of emotional or behavioural problems compared with the children of the less anxious mothers. From birth onwards, parents develop a repertoire of practical parenting skills, derived from their own experience of being parented, advice from kin and community networks, and social and cultural norms.

### Parent-infant interaction and attachment patterns

The quality of parents' interaction with their babies and young children is known to influence children's expectations about relationships not only during childhood but also in later years.<sup>30</sup> Having parents who can sensitively discern and respond to their baby's communications and help the baby regulate their emotional states will help the baby develop the capacity to recognise their own emotions and a sense that intimate relationships can be a source of comfort at times of stress. Research in neurobiology and neurophysiology is making links between babies' physiological states and neurobiological development and the quality of the caregiving context in which they are growing up, and there are some indications that abusive interactions can have long-lasting physiological or neuroanatomical effects on the child's developing brain.

A parent's capacity to respond to their child, particularly when the child is fearful or distressed, will inform the quality of the attachment that the child forms with them.<sup>31</sup> This attachment relationship forms a blueprint for later intimate relationships.<sup>31</sup> Attachment theory, as proposed by Bowlby and modified since, has stimulated an extensive body of research, much of which has implications for young children's mental health.<sup>32</sup> Bowlby's clear exposition of the importance of facilitating young children's developing attachments to their main caregivers has underpinned many important developments in childcare practice for those aged 0 to five years. Young children are no longer admitted to hospitals without their parents. Nurseries and daycare facilities (in principle at least) use key-workers with whom children are encouraged to develop special relationships, and adoptions are, where possible, completed while children are young.

Children's attachments can be classified in four ways; secure, insecure avoidant, insecure ambivalent and disorganised, and a child may have a different attachment pattern with each of their parents. Securely attached infants perceive their caregiver as a reliable source of comfort and safety in stressful situations, whereas infants with insecure or disorganised attachments do not, and use various different strategies to manage their distress on their own. Children with insecure avoidant attachments appear to be

undisturbed by stressful events like separation from their parent, but in fact heart rate monitoring would show that they are physiologically highly stressed.<sup>31</sup> Children with insecure ambivalent attachment are intensely distressed by stressful situations but find it difficult to be soothed by their parent.<sup>31</sup> Children with disorganised attachments do not have a coherent attachment strategy but may use a mixture of proximity seeking, avoidance and resistance, or appear fearful of their carer.

Insecure attachments are associated with increased rates of emotional and behavioural problems especially in families facing other adversities, whereas secure attachments serve a protective function. Children classified as having disorganised attachments often come from families which face marked socioeconomic adversities, or they are often the victims of maltreatment. These children are at greatly increased risk of having pre-school behaviour problems, though it is likely that their disorganised attachment status is only one element in an array of risk factors to which they have been exposed.

There is evidence that in 70 per cent of cases, infants will develop the same pattern of attachment towards their parent as their parent has towards their own attachment figures, suggesting that ways of responding at times of stress are passed unconsciously from generation to generation. Interventions designed to reduce insecure and disorganised attachments and increase attachment security are focused on increasing parents' understanding of children's emotional states and attachment needs and often on helping parents develop a new perspective on their own attachment history.

### Parenting style

Research into parenting has looked at what sorts of parenting style is most effective in promoting children's emotional wellbeing. One model developed by Maccoby and Martin identified four styles with different outcomes for the future mental health and functioning of children along two different dimensions, level of demand/control versus level of acceptance/rejection.<sup>33</sup>

#### 1. Authoritarian parenting

Children growing up in authoritarian families, with high levels of demand and control but relatively low levels of warmth or acceptance, tend to be less socially skilled, do not internalise standards of good behaviour and have lower self-esteem. Some of these children may appear subdued; others may show high aggressiveness or other indications of being out of control.

#### 2. Permissive parenting

Children growing up with indulgent or permissive parents, who are warm but provide low levels of demand and control, also show some negative outcomes, and by adolescence tend to be more aggressive, immature, irresponsible and lacking in independence.

### 3. Neglecting parenting

Neglecting parents provide neither warmth and acceptance nor adequate demand and control. Their children tend to show disturbances in their relationships with peers and with adults. At adolescence, youngsters from neglecting families are more impulsive and antisocial, less competent with their peers, and much less achievement oriented in school.<sup>34</sup>

### 4. Authoritative parenting

These parents provide high levels of both control and warmth, setting clear limits but also responding to the child's individual needs. Their children typically show higher self-esteem, and are more independent, are more likely to comply with parental requests, and may show more altruistic behaviour as well. They are self-confident and achieve greater educational success.

The limitation of this type of classificatory approach to parenting is that it can appear to play down the impact of contextual and child factors. It is important to stress that parent-child relationships are not simply the result of the adult's parenting style. Children with difficult temperaments will tend to elicit authoritarian parenting, while children with easier temperaments will be easier to parent in an authoritative way. In some stressful circumstances, parenting is almost inevitably disrupted. There is plenty of evidence, however, that parents who are warm and affectionate, in the context of clear, firm limit-setting, will have a positive impact on their children's mental health, and that authoritative parenting can mitigate the adverse effects of other stressors.<sup>35</sup> These general principles are the basis for a wide variety of parent education initiatives.

### Physical punishment

There is considerable debate about the effectiveness and longer-term impact of physically punishing children. The legal framework in the UK permits parents to smack children as long as it does not leave a mark, but there is widespread opposition to this policy, with campaign groups demanding that the UK follow the Swedish example and ban all physical chastisement of children. Smacking is not more effective than non-physical forms of discipline, and it demonstrates to children that problems can be solved by physical aggression rather than in non-violent ways (see **Chapter 5** for a more detailed discussion on smacking).<sup>36</sup>

### Child maltreatment

Physical abuse, sexual abuse, emotional abuse and neglect will often cause behavioural and emotional disturbances in babies and young children, as well as mental health problems and other adverse outcomes in adolescence and adult life. Young children who are being or have been emotionally abused, may have a whole range of mental health problems, including defiance and aggression, withdrawal, lack of interest in learning and disturbed relationships with adults.<sup>37</sup> Sexually abused young children may

become involved in sexually explicit play with their friends or be sexually provocative with adults. Many, but not all, abused children will have longer-term physical and mental health problems.<sup>38</sup> A proportion (around 30%) of adults abused as children will go on to abuse their own children. The focus of child protection must not only be on identification of existing abuse, but also on family support to reduce the likelihood of abuse occurring in the first place. See **Chapter 5** for further, more detailed, discussions on child maltreatment.

## 7.9 Non-parental care

### Child care

For many parents, finding child care while they work is a necessity. This may be provided in various ways within and outside the home, such as by members of the extended family, childminders, nurseries, nannies and au pairs. Research into the effects of non-parental daycare on babies and young children has produced mixed results. High-quality early intervention studies have shown clear social, cognitive and academic benefits for economically disadvantaged children. An American longitudinal study looking at the impact of different types of early child care, found that higher-quality care was associated with small but significant improvements in cognitive and academic performance.<sup>39</sup> Longer hours of care, especially in the first year of life and in daycare centres rather than with childminders, was associated with later higher rates of problem behaviours.

Good-quality daycare is characterised by high staff–child ratios, individualised rather than institutionalised care, effective key-worker systems, good staff–parent communication, emotionally warm interaction that is sensitive to the child’s verbal and non-verbal signals and cues, and the provision of varied and stimulating activities within a structured day. Similar features can be used to evaluate the quality of other non-parental care arrangements such as childminders or nannies. Public health guidance on the promotion of cognitive, social and emotional development of vulnerable children through early education and childcare is currently being developed by NICE.

### Fostering and adoption

For adults who were fostered long term, adopted, or brought up in an institution, following neglect or abuse from their birth parent, the personal and social outcomes are most favourable among those who were adopted and least favourable among those brought up in institutions, with those in long-term fostering in an intermediate position. All these groups of children are at increased risk of mental health problems. A large 2003 English survey of children aged five to 10 years in local authority care, found 42 per cent had a mental disorder, compared to 8 per cent of children living in private households. The widespread belief that early adoption is much more likely to be successful, because the child will benefit from stable early relationships with the adoptive parents, remains broadly true, but research shows that later adoptions can also work well. There is a trend to place children, where possible, with extended family, and

also for open adoptions, with contact between the adoptive and biological families.<sup>40</sup> The psychological impact of open adoption has yet to be fully researched and the debate about cross-cultural adoption continues. Fostering and adoption are more likely to work for the mutual benefit of carers and children, where care is taken in establishing the initial placements, and the families have specialised support and help available when they need it.<sup>40</sup>

Those children who have typically spent their early years in poor-quality institutional care will tend to have long-term problems with social functioning, even when adopted into more favourable circumstances, though adoption is likely to be the best available alternative for them.

## 7.10 Social risk and protective factors

### Socioeconomic disadvantage

Poverty is associated with a higher risk of both physical and mental illness across the lifespan, and also with premature death. Children in the poorest households are three times more likely to have a mental illness than children in the best off households. Conduct disorder (severe behaviour problems) is three to four times more common in poor families from poor neighbourhoods. Social class differences in rates of behaviour problems emerge early and are well established by the age of three years. It has been suggested that it may be the extremes of inequality in British society and the impact of social exclusion rather than just having a low income in itself which has a particularly negative effect on families and children. Poverty is usually only one of many challenges facing disadvantaged families, who may also have to cope with poor housing or homelessness, unsafe environments, inadequate local amenities and poor nutrition. How well a family manages to function, in the face of chronically debilitating problems like these, will influence how far socioeconomic adversity impacts on their children's mental health. These chronic adversities are characteristically (but not exclusively) associated with inner-city life. Black and minority ethnic families and children may experience similar complex constellations of disadvantage and racism, often compounded by poor access to culturally sensitive services.<sup>41</sup> Consequent reluctance to access services may result in any mental health issues becoming more severe before assessment and support can be provided. Refugees, with the additional psychological stress of an enforced move to a unfamiliar society, and an uncertain future, are also likely to live in conditions of multiple adversity, with a consequent impact on their children's mental health. In some families, multiple stresses and low income may be reflected in the children developing behavioural and emotional problems.<sup>42</sup>

### Housing and homelessness

There is evidence that inadequate housing is associated with an adverse effect on children's mental health.<sup>43</sup> Overcrowding has been identified as a variable which, alongside other risk factors, is associated with increased rates of psychiatric disorder in

children. Homeless families have also been identified as a group with particular mental health needs that are often unmet. A longitudinal study of homeless families found high levels of mental health problems in homeless children and their mothers, which persisted in a substantial minority after re-housing (for further details on the relationship between housing and child health see **Chapter 3**).

### **Social isolation and social support**

The birth of a baby, especially a first child, involves a considerable number of social and psychological adjustments on the part of both parents. This transition can be facilitated by the support of kin and community networks, which can have a protective effect.

Developing a social support structure, often among parents themselves, or using volunteers, is a prominent feature of many initiatives intended to improve parenting skills and children's health. But it is important to remember that parents are active participants in the creation of their own social environments, and those parents most likely to abuse or neglect their children may be least likely to develop and utilise community support networks. These parents will need long-term multidisciplinary professional support to develop and maintain their parenting skills. Short-term interventions at key times with vulnerable groups can also be worthwhile. A follow-up study of mothers at high risk for low birthweight babies, who had had a programme of social support in pregnancy, found at follow-up when the children were aged seven years, that there were fewer behaviour problems among the children and less anxiety among the mothers in the intervention group.

## **7.11 Interventions to reduce mental health problems**

The importance of intervening early with families to promote mental health and wellbeing is widely recognised, in order to meet young children's mental health needs, minimise risk factors and set them on successful developmental trajectories. Too often, disadvantage and parental problems impact on young children's emotional development and mental wellbeing with potentially lifelong consequences, as one negative experience paves the way for another. These disadvantaged children then become the parents of the next generation, and may reproduce their own poor experiences of parenting with their own children. Much is known about the risk factors in children, families and the environment that lead to subsequent mental health problems and other poor outcomes. The complex interaction of these risk factors can be mitigated by integrated interventions, which have both mental health benefits and demonstrable longer-term economic benefits, as the financial burden on society of later mental health and social problems is reduced. The benefits of investing to interrupt cycles of disadvantage are recognised across the political spectrum, yet early intervention initiatives are not yet universally in place.

## Frameworks

Health services and social services in the UK use two similar but not identical frameworks to organise their work in promoting young children's mental health. The two frameworks are described in **Boxes 7.1** and **7.2**.

### Box 7.1: Four-tier framework for CAMHS

The majority of children with emotional and behavioural problems will receive interventions at tier one or two.

#### Tier one: Primary or direct contact services

Workers in this tier include GPs, health visitors, voluntary sector workers, social workers, nursery workers, etc. These workers influence children's mental health as an aspect of, rather than the primary purpose of their work. They may be involved in aspects of mental health promotion, explicitly or otherwise, and are well placed to identify and help many children with mental health problems, or their families, without referring them to specialist services. They can be supported in doing this more effectively through training and supervision.

#### Tier two: Interventions offered by individual specialist child and adolescent mental health professionals

In this tier, individual professionals with specialist mental health training work may work directly with young children and their families, or supervise and train those in tier one. These individuals may have a variety of professional qualifications in, for example, psychology, psychiatry, social work, and psychotherapy. A community psychiatric nurse or a psychotherapist offering supervision to health visitors and children's centre staff, a psychiatrist providing regular consultation in a special needs nursery, or a clinical psychologist running a clinic for sleep and behaviour problems are examples of ways in which tier two professionals might be involved in promoting mental health in 0 to five year olds. Children's primary mental health workers with a specific remit to provide consultations and outreach work in tier one are working in many parts of the UK. Psychologists working in child development clinics also provide a specialist service at this level for young children, especially those with developmental delay and associated behavioural problems. An adult psychiatrist may provide a perinatal service identifying and treating mothers with perinatal mental health problems.

**Tier three: Interventions offered by teams of staff from specialist CAMHS**

Professionals in this tier may have similar backgrounds to those in tier two, but work in coordinated multidisciplinary teams with referred families, rather than as lone professionals. They offer integrated multidisciplinary assessment and management. Young children with severe behaviour problems or attachment issues may be assessed and treated in tier three settings. Unless particular teams have a special interest relating to younger children and their families, much work at tier three may be focused on school-age children and adolescents.

**Tier four: Very specialised interventions and care**

Work in this tier involves multidisciplinary teams treating highly specific and complex problems, including, for example, services for children with severe eating disorders, or the assessment and treatment of young children with complex presentations following abuse. For older children and adolescents, tier four interventions include inpatient and day patient provision.

This tiered framework described in **Box 7.1** is classified according to the training and configuration of the professionals providing the service, linking to the complexity of need in the children. Within children's services more widely, interventions are classified on a spectrum, based on the complexity of the child's needs, as presented in **Box 7.2**.

**Box 7.2: Classification of children's services**

**Universal services** work with all children and young people. They promote and support mental health and psychological wellbeing through the environment they create and the relationships they have with children and young people. They will be equivalent to tier one services in the CAMHS framework.

**Targeted services** work with children and young people with specific needs – for example, learning difficulties or disabilities, school attendance problems, family difficulties, physical illness or behaviour difficulties. Child and adolescent mental health professionals working at tier two work with targeted groups such as children in a school who have emotional or behavioural problems. Some CAMHS multidisciplinary tier three teams will also work at a targeted level with children with more complex specific needs such as looked after children.

**Specialist services** work with children with complex, severe or persistent needs. This includes children and young people in tier three and four CAMHS services, as well as those in specialist educational settings, care homes intensive foster care and secure settings.

### Policy context

In the first few years of the 21st century, the emotional wellbeing and mental health of young children was addressed within a comprehensive policy context set out within the NSF for Children, Young People and Maternity Services and the ECM Framework underpinning the Children's Act of 2004. Emotional wellbeing and mental health was seen as just one aspect of promoting children's healthy development and positive contribution to society. The emphasis throughout was on holistic support for children's needs and the needs of their families, provided by agencies and services working together in an integrated way. This theme was developed by the CAMHS review of 2008, which underlined the need for flexible joined-up working between agencies, adequate training on mental health and emotional wellbeing for all staff working with children, plus the availability of good-quality information on mental health and psychological wellbeing for children, young people and their carers.<sup>44</sup> The Families at Risk review in 2008, which underpinned the Think Family strategy,<sup>45</sup> focused on the need for integrated interagency interventions for families with multiple problems and adversities, in order to break the cross-generational cycle of disadvantage, which was estimated to affect about 140,000 of the 13.8 million families in England.

Following a change of Government in May 2010, the new mental health strategy,<sup>46</sup> applicable across the lifespan, has focused on choice for service users, increased use of outcome measures, and increased local control of public finance. At the end of 2011, a Troubled Families Unit was established within the Department of Communities and Local Government, to focus on 120,000 families with multiple problems (whose children are at increased risk of emotional and behavioural problems and other adverse outcomes). The plan is for this to fund 40 per cent of local authorities' costs in intervening intensively with these families, payable only once certain defined positive outcomes have been achieved. The Government also plans to provide nursery places for 260,000 disadvantaged two year olds.

Although early intervention is recognised as important, widespread public spending cuts have severely curtailed the early intervention services available for children and families. A 2011 NSPCC review, found predicted cuts in children's social care spending averaging 24 per cent between 2010/11 and 2011/12, with seven councils planning to cut children's social care budgets by 40 per cent.

### Information sources

Families need to be able to access reliable information about children's emotional wellbeing or mental health problems, and this need is more pressing as support services are being cut. Many families, children and young people will access information and support from friends or family and via the internet. Young Minds and the Royal College of Psychiatrists are examples of organisations with websites that provide information on mental health issues for parents and young people; the Understanding Childhood

website provides downloadable information sheets on the problems of young children in particular. Reality TV focusing on the management of behaviour problems is a source of information for many parents. Health visitors will provide basic information for all new parents, and identify those who may need more intensive interventions and support.

Those working with babies and young children also need access to information about best practice in order to provide quality services. The Early Years Foundation Stage Framework provides standards which providers of education and care to children aged 0 to five years are expected to follow. The importance of developing a positive sense of self, good social relationships and a basic understanding of emotions is recognised as an essential foundation for emotional wellbeing and successful learning. Other useful sources of information for staff working with young children include websites such as the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO), which draw together research and best practice examples from statutory and voluntary sector service providers.

### Service provision

Interventions to promote young children's mental health are delivered by a range of agencies, including health services, social services, education services and the voluntary sector. These are integrated to varying extents in different parts of the UK. In the first decade of the 21st century, some local authorities developed pooled budgets and integrated management systems to develop early intervention programmes in their localities, but this is not universal. Nottingham has a strategic planning partnership bringing together public, private, community and voluntary sector agencies, committed to developing a comprehensive early intervention programme. This involves 16 different but complementary early intervention projects and programmes at antenatal, perinatal, early years and school age stages of the life-cycle, targeted at those individuals and families who are very likely to have difficulties without effective interventions. Some of these programmes and projects are among those described in the follow paragraphs.

### Sure Start and children's centres

The Sure Start programme, launched in 1998, at a cost of £500 million, was a 10 year anti-poverty programme which targeted all families with a child under four years living in more than 500 of the most disadvantaged communities in the UK.<sup>47</sup> It was an innovative programme, in that it aimed to have a beneficial impact on a whole area, not on a smaller group of targeted individuals. Sure Start Local Programmes (SSLPs) were expected to provide five core services: outreach and home visiting; support for families and parents; good quality play/early learning/childcare; healthcare for children and parents; and support for children (and their parents) with additional needs and disabilities. These programmes were given relative freedom in how they delivered these services and met the limited targets set by the Government.

The SSLPs that were more successful were those with better leadership and clearer objectives, where there was a specific focus on identifying and involving the most disadvantaged families. Because of the diversity of provision in local Sure Start programmes, and an expansion and change in the programme when SSLPs were changed into Children's Centres in 2006, research into the outcomes of Sure Start has been extremely complicated. The National Evaluation of Sure Start Team has been following up children and families living in SSLP areas and comparing them with similar children and families being followed up in the Millenium Cohort Study who do not live in SSLP areas.

Positive findings in the 2010 evaluation (of five year olds), show that parents in SSLP areas had greater life satisfaction, engaged in less harsh discipline, and provided a less chaotic and more cognitively stimulating home environment. More of the parents in SSLP areas who had been out of work when their children were aged three years were in work once their children were five years, in comparison with similar families from non-SSLP areas. Although these positive findings might be expected to promote emotional wellbeing and mental health for young children in areas where there were SSLPs, the evaluation did not find any reduction in children's behaviour problems. Another issue which was problematic in some SSLP areas was ensuring that the families who could most benefit from Sure Start services received a service. There is a need for specifically targeted services for groups with particular needs, like teenage parents or parents with significant mental health problems alongside universal or area-based services like Sure Start (for further details on child poverty and Sure Start schemes see **Chapter 3**).

### Perinatal/infant mental health services

Early identification and treatment of mothers with postnatal depression or other postnatal mental health problems is likely to ameliorate the negative impact on their child's development, though further research is needed in this area.<sup>48</sup> Perinatal services are patchy across the UK, with some areas served by multiagency perinatal networks including midwives, health visitors, adult psychiatrists, social workers and child and adolescent mental health workers, but many providing partial services in a much less integrated way. Parents from black and minority ethnic backgrounds may have particular difficulties accessing support and treatment.

### Support for families with infants and toddlers

All children born in the UK have a health visitor allocated at birth, who is well placed to identify those families that will need targeted support to mitigate risk factors and promote emotional wellbeing. Health visitors are in a position to identify parents with postnatal depression or other problems and help them seek treatment, and to advise over any difficulties, such as with feeding, sleeping and behaviour. There are a number of programmes in use in certain parts of the country to provide a structured framework for additional support, such as the Solihull Approach, which combines psychotherapeutic

and behavioural concepts and encourages parents to contain and reflect on their own and their babies' emotions, respond sensitively to their babies' communications, and use behavioural techniques to shape their babies' behaviour.

### Family Nurse Partnerships

The FNP Programme is a Government funded programme involving two years of regular structured home visiting for first-time teenage mothers during pregnancy and the child's infancy. Family nurses, who may have a midwifery or health visiting background, build supportive relationships with the mothers and help them to adopt healthier lifestyles, care for their babies well, and promote secure attachments. The programme is running in over 50 areas in the UK and due to expand to offer 13,000 places by 2015. The programme is based on the NFP programme which originated in the USA. The NFP has been extensively evaluated and has been shown to have a number of positive benefits, including reduced levels of child abuse and better emotional and language development, plus fewer subsequent pregnancies and less reliance on benefits. The programme is subject to rigorous evaluation in the UK, with initially promising results. A randomised controlled trial is due to report in 2013. If the US findings are replicated, this programme has the potential to have a beneficial impact on the emotional wellbeing of this particular high-risk group of children (see **Chapter 3** for further details on the FNP programme).

### Parenting programmes

After thorough review of the evidence, the NICE guidance recommended that structured parenting programmes should be offered to parents of children aged 12 years or under whose children have severe behaviour problems, and also offered as first-line treatment in ADHD.<sup>49,50</sup> The aim of these programmes is to support parents in relating to their children in ways that promote a warm and nurturing relationship, with appropriate limit setting, and help parents avoid negative interactions with their children. The guidance emphasises that these programmes should be delivered by experienced facilitators who adhere to a specific programme whose efficacy has been demonstrated through randomised controlled trials. The programmes should be based on social learning theory and aim to enhance parent-child relationships, with role-play and homework tasks to help the parents develop confidence and learn new skills. There is not much research into the effectiveness of parenting programmes where children are under three years of age, but the research that exists suggests that these programmes improve the emotional and behavioural adjustment of younger children at least in the short term.<sup>5</sup>

One widely used and well-evaluated structured group-based parenting intervention is the Incredible Years series of parenting programmes.<sup>51</sup> The original programmes focused on children aged three to 12 years, but programmes for parents of babies and toddlers are now also available. The programmes involve looking at video examples of parent-child interactions as a basis for discussion and role-play.

Another well-evaluated intervention is The Triple P Positive Parenting Programme.<sup>52</sup> This provides a multilevel framework that allows parents to access different types and intensities of assistance in a stepped approach. Level one involves dissemination of media messages about positive parenting. Levels two and three involve short interventions in primary care, focused on the management of specific problem behaviours. Level four involves more extensive parenting programmes which cover a range of problem behaviours, delivered to individuals or in groups, often with telephone support. Level five programmes are intended for families where parental problems such as depression also need to be addressed. The Pathway programme is designed for parents at risk of maltreating their children, and includes sessions on anger management, and a focus on changing any negative attributions that parents may have about their children.

Children and Young People's Improving Access to Psychological Therapies (IAPT) is a Government-funded project that is providing additional training across the UK in evidence-based interventions, including the delivery of structured parenting programmes for parents of three to 10 year olds. Although structured parenting programmes are available in many parts of the UK, they are not universally available, and not all the parents who could benefit are able to access them.

### Video interaction guidance

All evidence-based parenting programmes emphasise the need to build and maintain a warm and nurturing relationship between parent and child, so that the child feels recognised as an individual, loved and supported. This is the basis on which limit setting and discipline can then be established. Where there are tensions or problems in the parent-infant or parent-child relationship, video-based interventions like video interaction guidance can enhance parental ability to perceive and respond to the child's communications in an attuned and sensitive way. This delicate communicative dance is promoted by filming the parent and child together in an enjoyable activity and then reviewing clips of attuned interaction with the parent to develop their skills and confidence in building a positive relationship with their child. Research has found that video-feedback techniques, especially where the focus is on reinforcing and extending sensitive interactions, has a positive effect on parenting skills and parental attitudes towards the child, as well as beneficial effects on the child's development.<sup>53</sup>

## 7.12 Current situation and future prospects

Although a great deal is now known about the causes of emotional and behavioural problems in young children, and how they can be ameliorated, the availability and accessibility of effective interventions remains very patchy in the UK. After almost a decade of increased funding and more integrated development of children's services, the recession has brought widespread cuts, alongside increasing poverty and family stress. Despite some new initiatives in early intervention and some limited funding for interagency work focused on families with multiple problems, in general young children

and their families will have more challenges to their emotional wellbeing and less support available than in recent years. Although there is good evidence that early intervention can reduce levels of emotional and behavioural problems and prevent later problems that are both distressing and expensive to manage, the political will to fund a sustained and comprehensive programme of early intervention is not currently evident. Radical changes to the commissioning of children's services and increased emphasis on competition between providers will make the provision of coherent interagency networks of services for families with young children increasingly difficult to provide. The impact of these enormous organisational upheavals alongside an expectation to make financial savings will fall disproportionately on the most disadvantaged children and families. There is a risk that the limited funding available will increasingly be diverted from early intervention programmes into more pressing crisis management. Although the argument for the benefits of early intervention to promote young children's emotional wellbeing has been convincingly made, it has not yet been won. More needs to be done to persuade the public and the Government that young children with emotional and behavioural problems deserve to receive adequate and timely support and assistance. This is needed not only to alleviate their distress, but also to minimise the adverse impact on their subsequent development. The early years provide a unique opportunity to promote young children's resilience and wellbeing, reduce the potential for later mental health problems, and minimise the development of entrenched negative behaviours and their subsequent costs to society. It is crucial that this opportunity is not missed.

### 7.13 Recommendations

- Severe adversities and maltreatment in infancy and the early years can have a lifelong impact on a child's brain development, physiological reactions to stress and later mental and physical health. Devoting resources to supporting families with young children can potentially prevent a proportion of these adverse outcomes, with benefits both for the individual children and in avoiding later financial and other costs for society.
- Many of the risk factors for mental health problems in children are often found in association with each other. Poverty, poor housing, domestic violence, parental mental ill health and drug abuse may cluster together in families, and have a negative effect on children that is multiplicative rather than additive. As less money is spent on social services, family support and health care, it is important that it is targeted towards effective services that are accessible to those most in need.
- Inequalities in access to mental health services need to be addressed. Interpreters need to be available, staff need to be trained to be culturally aware, staff need to be flexible in how and where services are offered.
- As the coordinating role of social services and the local education authority is reduced, with more emphasis on services provided by a range of voluntary and statutory providers seeking funding in competition with each other, maintaining interagency networks remains important if holistic and integrated care is to be provided to families with complex needs.

- The current focus on outcomes-based evaluation of services is an opportunity to learn more about what works to improve children's emotional wellbeing and mental health. Similarly, the introduction of CAMHS PbR planned for 2014 will help to encourage clarity about the focus of CAMHS interventions. It is important that both these changes to practice do not become bureaucratic exercises where form-filling and data collection interfere with the development of creative relationships between families and professionals.
- There is good evidence that providing structured parenting programmes based on social learning principles for parents whose children aged three to eight years have severe behaviour problems, is an effective intervention with the potential to divert children from negative developmental trajectories that are distressing to them, their families and their neighbourhoods and expensive to society. Some programmes, like Triple P, are designed in a stepped sequence according to the level of need that a particular family might have.
- There is emerging evidence that promoting parents' attunement to their child's communications, using video-based techniques, can develop parental skills and help troubled parent-child relationships get back on track.
- Parents and staff working with young children need to be able to distinguish between normal and abnormal developmental trajectories so that, when necessary, appropriate referrals can be made for specialist assessments and interventions.
- Sufficient specialist CAMHS staff should be available in each locality for assessments and interventions to be offered in a timely manner.

