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Supporting children's mental health and wellbeing

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About this free course

This free course is an adapted extract from the Open University course .

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Contents

Introduction and guidance

Introduction and guidance

This free badged course, *Supporting children's mental health and wellbeing*, lasts 24 hours and is comprised of eight sessions. You can work through the course at your own pace, so if you have more time one week there is no problem with pushing on to complete a further study session. The eight sessions are linked to ensure a logical flow through the course. They are:

1. Setting the scene by looking at the past
2. Increasing your knowledge of mental health
3. Mental health promotion and education
4. A global view of children's mental health and wellbeing
5. Wellbeing and mental health in education settings
6. Professional support for children and their mental health
7. Exploring some of the interventions to support children's mental health
8. The influence of screen time on young children's mental health and wellbeing

Each session should take you around 3 hours. There are a number of activities throughout the course where you are asked to note down your response. A text box is provided for you to do this, however if you would prefer to record your answers in another way that is fine.

At the end of each session there is also a quiz to help you check your understanding. And, if you want to receive a formal statement of participation, at the end of Sessions 4 and 8 there is a quiz which you need to pass.

After completing this course, you should be able to:

- understand the influences on mental health in young children age 0–5
- identify the factors that contribute to good mental health in children
- explore national and global influences on children's mental health
- develop knowledge about strategies and interventions to improve mental health in children
- examine how adults and society can support children's mental health and wellbeing.

Moving around the course

In the 'Summary' at the end of each session, you will find a link to the next session. If at any time you want to return to the start of the course, click on 'Full course description'. From here you can navigate to any part of the course.

It's also good practice, if you access a link from within a course page (including links to the quizzes), to open it in a new window or tab. That way you can easily return to where you've come from without having to use the back button on your browser.

The Open University would really appreciate a few minutes of your time to tell us about yourself and your expectations for the course before you begin, in our optional start-of-course survey. Participation will be completely confidential and we will not pass on your details to others.

What is a badged course?

While studying *Supporting children's mental health and wellbeing* you have the option to work towards gaining a digital badge.

Badged courses are a key part of The Open University's *mission to promote the educational well-being of the community*. The courses also provide another way of helping you to progress from informal to formal learning.

Completing a course will require about 24 hours of study time. However, you can study the course at any time and at a pace to suit you.

Badged courses are available on The Open University's OpenLearn website and do not cost anything to study. They differ from Open University courses because you do not receive support from a tutor, but you do get useful feedback from the interactive quizzes.

What is a badge?

Digital badges are a new way of demonstrating online that you have gained a skill. Colleges and universities are working with employers and other organisations to develop open badges that help learners gain recognition for their skills, and support employers to identify the right candidate for a job.

Badges demonstrate your work and achievement on the course. You can share your achievement with friends, family and employers, and on social media. Badges are a great motivation, helping you to reach the end of the course. Gaining a badge often boosts confidence in the skills and abilities that underpin successful study. So, completing this course could encourage you to think about taking other courses.

How to get a badge

Getting a badge is straightforward! Here's what you have to do:

- read each session of the course
- score 50% or more in the two badge quizzes in Session 4 and Session 8

For all the quizzes, you can have three attempts at most of the questions (for true or false type questions you usually only get one attempt). If you get the answer right first time you

will get more marks than for a correct answer the second or third time. Therefore, please be aware that for the two badge quizzes it is possible to get all the questions right but not score 50% and be eligible for the badge on that attempt. If one of your answers is incorrect you will often receive helpful feedback and suggestions about how to work out the correct answer.

For the badge quizzes, if you're not successful in getting 50% the first time, after 24 hours you can attempt the whole quiz, and come back as many times as you like.

We hope that as many people as possible will gain an Open University badge – so you should see getting a badge as an opportunity to reflect on what you have learned rather than as a test.

If you need more guidance on getting a badge and what you can do with it, take a look at the OpenLearn FAQs. When you gain your badge you will receive an email to notify you and you will be able to view and manage all your badges in My OpenLearn within 24 hours of completing the criteria to gain a badge.

Get started with Session 1.

Session 1: Setting the scene by looking at the past

Introduction

In the first session of this course, you will look at the history of children's mental health. Until the middle of the twentieth century, following the Second World War and the formation of government welfare services, children's mental health was not recognised as the significant issue it is today. However, some children will have experienced mental health problems, even if these were left undiagnosed, and you will be examining some of the reasons why this might have happened.

You will look at a news account about children's mental health and consider why there are currently reported increases in the numbers of cases of children with compromised mental health, and you will be encouraged to identify some of the reasons why this might or might not be the case. You will also be introduced to some of the 'language' associated with children and their mental health. This will hopefully make the content in later sessions more familiar to you. And finally, you will be encouraged to think about the resources within the child, the family, their community and wider society that can help children to develop ensuring good overall mental health.

It is important to highlight that contemporary Western views about children and mental health are not going to be held globally; some cultures as well as religions hold beliefs that mean they do not recognise mental health issues as an illness. Instead, the causes of behaviours in children that are outside the norm are sometimes attributed to other explanatory models, a contentious example being that a child is possessed by evil spirits.

Now listen to the following audio in which Liz Middleton, one of the course authors, introduces the session.

Audio content is not available in this format.
Audio 1

By the end of this session, you will be able to:

- describe an overview of the history of children and mental health
- outline the reasons why there is an increase in awareness of children's mental health
- identify selected factors that can impact children's mental health and wellbeing.

The Open University would really appreciate a few minutes of your time to tell us about yourself and your expectations for the course before you begin, in our optional start-of-course survey. Participation will be completely confidential and we will not pass on your details to others.

1 Historical perspectives of children's mental health

The recognition that children may be vulnerable to developing diagnosable mental health conditions has started to emerge over the last hundred years or so. This is partly because, until modern times, children were regarded as little more than 'adults in waiting' and childhood was not regarded as a distinct life stage as it is today. There was a different understanding about how children develop and a lack of awareness that children think differently to adults. Another reason why it was thought that children could not be regarded as being mentally unwell is because behavioural problems were viewed as being caused by children being 'bad' rather than 'mad' (Rey et al., 2015). Children who did not conform to the expected norms of behaviour were often marginalised from society, punished harshly and labelled in pejorative ways.

The next section includes a timeline of some of the key events relating to societal views and developments in relation to children's mental health. The sources used for this timeline include historical accounts from the field of child psychiatry as well as recently written reflections on the history of children's mental health.

1.1 Key events in the history of children's mental health

Below is a timeline of key events, predominantly drawn from the United Kingdom, that have influenced the ways that children's mental health is viewed in countries such as the UK.

1800s: lunatic asylums emerged and children regarded as psychiatrically unwell, including those with learning disabilities, were institutionalised and removed from mainstream society.

1895: Henry Maudsley, a pioneer of psychiatry, wrote a psychiatry textbook posing the question 'how soon can a child go mad? … obviously not before it has some mind to go wrong, and then only in proportion to the quantity and quality of mind which it has'.

Figure 1 A poor child in Victorian times

The late 1800s: there was a lack of clarity about the causes of mental health conditions in children. However, during this time, a growing understanding developed that children could be affected mentally by the 'psychological damage' caused by grief, such as melancholia, or, to use a more contemporary phrase, depression.

1889: adolescence started to become recognised as a distinct stage of life, and puberty was recognised as a significant 'cause of insanity'. Maxime Durand-Fardel (1889), another doctor who was a pioneer in psychiatry, highlighted the existence of suicide in children.

1919–1930: educationists such as sisters Rachel and Margaret McMillan (1919) and Susan Isaacs (1929), who were pioneers in nursery education, published books to explain their views about the importance of early childhood education. Their work made significant contributions to understanding how children develop emotionally and socially. Their work and practice remains an influence in contemporary nursery education.

Figure 2 Susan Isaacs with children at The Malting House School

1936: Jean Piaget, a psychologist, developed his theory of children's cognitive development, which clearly demonstrated that children think in different ways to adults.

The Second World War (1939–45) had a profound impact on many children's mental health. The experiences of many children in the UK included being evacuated to places of physical safety away from their families to live with people who were unknown to them. In many cases, children's experiences had a negative effect on their emotional development and on their mental health.

In order to see the connection between challenging life events and how this impacts on children's mental health, in the next section you'll read about the real-life account of a woman remembering her experiences as a child during the Second World War.

1.2 Case study: the impact of war on children

Read the following case study about Sheila, a 6-year-old girl living in Birmingham in 1943 during the Second World War. Sheila's experience is based on the account of a woman in her 80s, but she vividly recalls the experience of this period of her life.

Figure 3 Evacuee children in the Second World War

Case study: Sheila

Sheila is 6, she is an only child and she lives with her mum. Until recently, they lived in a small house known as a back-to-back in the middle of Birmingham. It's 1942, the fourth year of the Second World War, and there have been many nights of bombing across the country. Normally, the area where Sheila lives is not affected because the bombs are usually targeted on the factories which are further east; however, the planes went off course and dropped a barrage of bombs, one of which hit Sheila's home and destroyed it.

For the last month, Sheila and her mum have been living with her aunt and her four cousins. Sheila has to sleep on the sofa because the house is so crowded. Each night, for the last week, the siren has gone off at 1 am to warn people that the planes are nearby. The siren means that they all must go to the nearest bomb shelter to wait for the planes to finish their mission.

Everyone is exhausted, food is in short supply and people are hungry. Sheila hates the noise caused by the explosions that happen after the bombs hit a target. However, it's almost worse waiting for the noise to happen. Sheila feels jumpy and anxious, and she knows she would feel better if she had Snowy, her much loved toy sheep. He had been with her all of her life and he was a dull grey with threadbare patches, and he smelt and felt like home. However, Snowy disappeared when their home was destroyed, and Sheila feels lost and alone without him. She feels that life will never be the same again.

Just as Sheila thinks that things can't get any worse, two things happen. Firstly, her dad – who is away in France fighting in the war – is reported as missing in action. This means that he may have been taken a prisoner, or he may have been killed, but they don't know which. The second thing that happens is that Sheila's mum finds a job in a factory. As money is tight, she decides to take the job, but this means that nobody is available to look after

Sheila. So Sheila is evacuated to the countryside, away from the bombing, to live with people who can look after her until it is safe to go back home.

The people who take in the evacuees are strangers; they often live on farms and some use the children as unpaid workers. Life is physically very hard because the children are required to get up early and do chores such as going out in the dark mornings in all weathers to collect eggs or milk cows.

Sheila joins the local school and, at first, she is a source of curiosity to the other children who can't understand her different accent but try to include her in playtime. However, Sheila is so miserable that she finds it difficult to respond to their attempts to include her, so the other children eventually stop trying to make friends. Sheila becomes withdrawn, finding it hard to speak, eat and sleep. She misses everything about home and feels completely alone in the world.

Sheila returns to her mother after the end of the war. Her life settles down into a routine with her mum, and she happily fits in to her old school again. It turns out that her father has been a prisoner of war, so he too returns home at the end of the war. He is deeply affected by his experiences but takes solace in his family and they go on to have a much-loved brother for Sheila.

Sheila's adverse childhood experience does not appear to affect her mental health in the long term; however, her experience as a child living through the terror of bombs falling from the sky during the night leaves her with a fear of loud noises, which never goes away. The feeling of loss and separation experienced as an evacuee leaves her with a strong desire to always be with people and have company; her engaging nature means that she has many friends who help to meet that need.

Activity 1 Exploring the mental health impact of being an evacuee in the Second World War

Allow about 10 minutes

Answer the following questions about the case study.

- What are the reasons why Sheila's mental health could be affected by her living conditions and external events?
- What events and circumstances appear to help her to recover from her experiences?

Throughout this course, you'll have the opportunity to record your answers to activities in interactive boxes and save them. No one else will be able to view them. If you'd like to, add your answers to the questions in the box below.

Provide your answer...

Discussion

The impact of Sheila's experience could have been very different: she could have experienced long term trauma, which could in turn have resulted in life-long difficulties with her mental health such as anxiety, depression and post-traumatic stress. It is not always obvious why some children are more vulnerable to the effects of adverse experiences than others, although there are several protective factors, which will be discussed further in this course. In Sheila's case, the absence of mistreatment during

her time as an evacuee, the return to a happy routine at home and many positive relationships will undoubtedly have helped her to heal and recover from the experience.

1.3 The Second World War in Europe

In Europe, the Second World War meant that many children were displaced from their home country and consequently suffered physical and emotional trauma. These accounts about children and war from Western Europe are historical, but it is important to remember that children in the present day are experiencing similar challenges in conflict zones around the world. In the next activity, you'll look at another child's experience of the war.

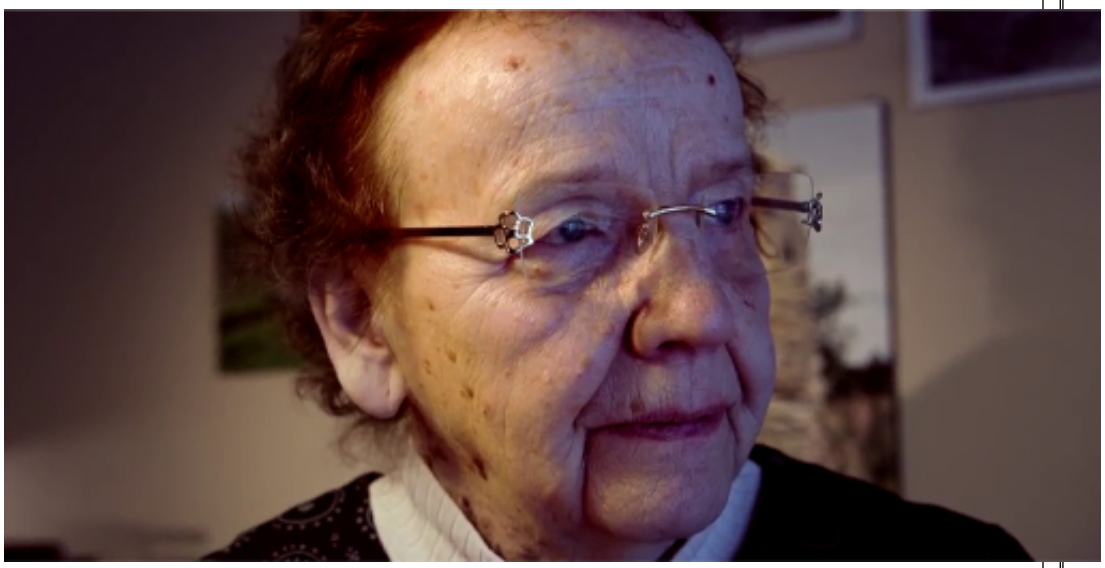
Activity 2 Irja's story

Allow about 10 minutes

This video recounts the experience of Irja, who as a child had to leave her home in Finland during the war. As you watch this short video, consider the factors that may have helped her to survive this experience.

Video content is not available in this format.

Video 1



Provide your answer...

Discussion

Irja highlights the harshness of living as a displaced person; however, what is evident in her story is the importance of remaining part of a family. The video also illustrates the importance of having a person's physical needs met; for example, having enough

to eat. The video also makes a link between the importance of having the basic physical need of clothing supplied as a factor that can contribute to positive mental health and wellbeing. The gift of the brown shoes meant that Irja was able to attend school, where she would have had the opportunity to develop emotionally, socially and intellectually.

1.4 Post-Second World War period: key events in children's mental health

Below is another timeline, focusing on post-Second World War events.

1949–1969: John Bowlby, who was a psychiatrist, started his pioneering work about children's emotional development shortly after the Second World War by studying the effect on children of separation from their mothers. From this work he developed his theory of attachment, which was first published in 1969.

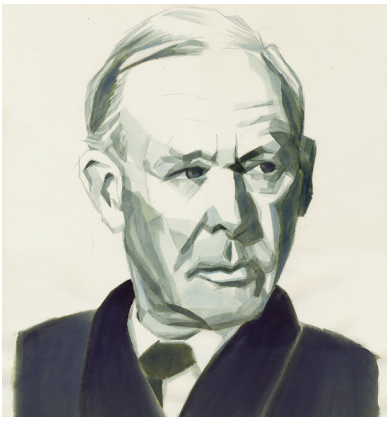


Figure 4 John Bowlby – the pioneer of attachment theory

1949: The United Nations International Children's Emergency Fund (UNICEF) was set up to improve the lives of children who had been affected by the Second World War.

1953: UNICEF became part of the United Nations and their name was changed to the United Nations Children's Fund. The work of UNICEF continues today, helping to improve the mental and physical health of children who are caught up in war and conflict around the world.

1959: The United Nations introduced the Rights of the Child, which meant that children became regarded as citizens with rights in many places in the world. Other significant events included the development of evidence-based therapies and forms of medication which were effective and safe to use in the treatment of children with mental health conditions.

Figure 5 Children in post-war Europe from UNICEF

1989: The United Nations Convention on the Rights of the Child was a global event that turned a spotlight on children and their welfare. Around this time, a number of cases emerged that highlighted the exploitation of children and this led to the creation of policies designed to protect children and improve their mental health. In England, the Children Act (1989) is an example of legislation that was passed to improve children's lives and wellbeing.

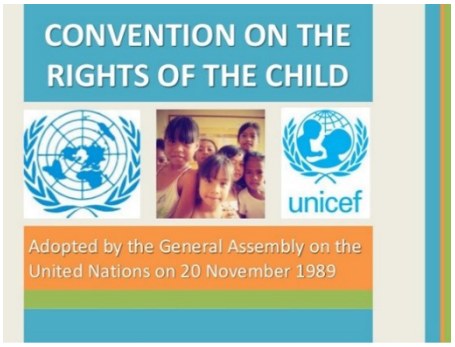


Figure 6 Convention on the rights of the child

1995: Children and Adolescent Mental Health Services (CAMHS) began to be set up across England and Wales, and elsewhere, to bring together multi-disciplinary teams of professionals to diagnose, treat and support children and young people with mental health conditions.

Activity 3 Reflecting on history

Allow about 10 minutes

How can looking at children's mental health through an historical lens help our understanding of the contemporary situation?

Provide your answer...

This brief overview of the history of children's mental health highlights that children have always experienced mental health problems. However, it is only in relatively recent times, that is, since about 1940, that this has become recognised as such and that specialist services and treatments have been developed. This section summarises some of the key events that have influenced the shift in the belief that children are not capable of experiencing mental health problems to the contemporary situation in many countries, where it is recognised that children can experience profound mental health conditions.

2 Contemporary children's mental health

The previous section explored a brief snapshot of the history of children's mental health and highlighted that children experiencing mental health problems is not a new phenomenon. Children have always had mental health problems, but because of their status in society, their needs have not always been recognised and addressed. Nowadays, in part due to advances in our ability to diagnose mental health conditions in children, it has been estimated that as many as 10%–20% of children have a diagnosable mental health condition (World Health Organization, 2019). For many, their issues will be in the 'mild-to-moderate' range, while others will have severe and possibly enduring mental health conditions. This situation is of concern to individuals and their families and also has long-term consequences for society. However, at this point, it is important to have a look at some of the evidence relating to the relatively high prevalence of mental health conditions in children.

Figure 7 Thinking about mental health in young children

Activity 4 Exploring some of the facts around children and their mental health

Allow about 15 minutes

Professor Tamsin Ford, a child psychiatrist, led a study about children and young people's mental health, and the findings were reported in a BBC news article. In a nutshell, the study was based on assessments completed with 10,000 child and adolescent participants. Follow this link to access the article (make sure to open the link in a new window/tab so you can return here easily):

Is young people's mental health getting worse?

As you read the article, consider that the report states that in 1999, the incidence of children with a mental health condition was estimated to be 11.4% of children below the age of 16. In 2017, the proportion was estimated to have increased to 13.7%. So, on the surface, over an 18-year period, there was a 2.3% increase in the number of children who were reported as having a mental health problem. However, clearly establishing how much of the reported rise represented an actual increase in children and young people experiencing problems, and how much is down to better awareness of symptoms and/or diagnosis, is challenging.

Consider the reasons given in the report for the possible increase in terms of proportionately more children having mental health conditions.

Provide your answer...

Discussion

As you read the report, you may have been struck by the fact that Ford was surprised that there had not been a bigger increase in the number of children being diagnosed with a mental health condition. You may have also noticed in the timeline that CAMHS was set up in 1995. This was a key event in addressing children's mental health because numerous specialist services were created to support children with mental health conditions.

Although this report states there has 'only' been a 2.3% increase in the number of children being diagnosed with a mental health condition between 1999 and 2017, this still means that there is a sizeable proportion of children living with a mental health condition. Clearly, it is important to consider the reasons why there are such significant numbers of children with compromised mental health, both to further our understanding, but also to support children to develop positive mental health. You will explore these issues in the rest of this course.

3 Resources that promote a child's mental health and wellbeing

There are many factors in children's lives that can help to contribute to their wellbeing which in turn can help them to have good mental health.

To illustrate this point, you will now look at the work of Urie Bronfenbrenner, an American sociologist who researched the interaction between the individual and their environment. Bronfenbrenner developed a theory of how each child's development is influenced by their relationship with the groups and communities around them as well as with wider society. His theory was named the bioecological model (1979) and he illustrated the theory in a diagram which put the child in the centre of a nest of circles. Moving out from the child, each circle represented a system around the child. This theory is useful to illustrate the influences on children's mental health.

In Figure 8, the systems around the child have been separated out to illustrate how we can think about the factors within each system.

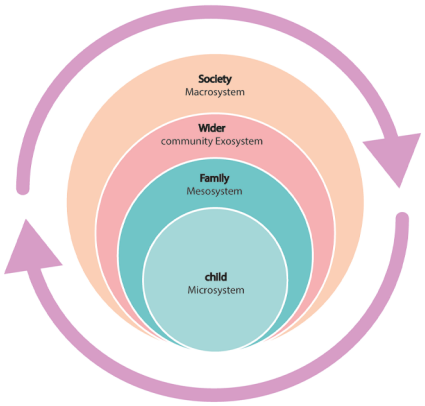


Figure 8 Systems around the child (adapted from Bronfenbrenner, 1979)

The inner circle represents the resources within the individual child (the microsystem), then moving outwards, the resources within their family (mesosystem) and local community (exosystem) such as pre-school/school or places of worship, and, finally, the outer circle (macrosystem) which represents the resources within wider society that help children to develop good mental health. Around each of the systems is the passage of time, suggesting that situations and circumstances evolve over time and will change as a matter of course in response to external events. The child themselves will also continue to grow and move across the systems as they move further into the world and away from their family networks.

Earlier in this session you saw how, at different points in history, wider social issues such as war have had a significant impact on how families function and the extent to which children thrive in more challenging environments.

You will find it helpful to return to these different systems as you examine how various practices and policies might affect children's wellbeing, and the ways that the different 'layered systems' might work together to promote more positive mental health in young children and their families, as well as the communities in which they live.

Activity 5 Identifying resources that can make a positive contribution to children's mental health

Allow about 10 minutes

Make a list of the resources within each of the circles that you think can make a positive contribution to children's mental health.

Provide your answer...

Discussion

The following are some suggestions of the resources that you may have listed for each of the systems. Don't worry if you included other resources or worded things in a different way. The main point is that each of the different systems has an influence on the others.

1. **Within the child (the microsystem):** determination, intelligence, resilience, perseverance, a sense of good wellbeing.
2. **Within the family (the mesosystem):** an emotionally responsive home with settled routines, good relationships, and all physical needs met. In Session 3, you will look at the important process of attachment. You will understand how the building of secure attachments in the early years can help to develop positive views of self and effective future relationships with others.
3. **Within the community (the exosystem):** good quality pre-schools and schools, health services, a safe environment with access to outdoor areas for play. You will have the opportunity to reflect on the ingredients that make up good quality care and education in Session 5. In the same session, you will focus on the significance of play for the promotion of children's mental health and wellbeing as part of the early years curriculum.
4. **Within society (the macrosystem):** laws that protect children and help prevent harm that can make the occurrence of adverse childhood experiences more likely. Positive societal attitudes that take account of children's rights will be a resource that you will explore more fully in Session 4.

Safeguarding laws in England are an example of the national approach that states that it is everybody's responsibility to protect the welfare of children, and therefore these are resources within society. You will be introduced to these laws in Session 5.

It is worth bearing in mind that even if children have many of the resources available to them, some children will still develop a mental health condition. And the opposite is also the case: children who have experienced a great deal of adversity and are missing many of the positive factors in the systems around them do not necessarily develop poor mental health.

4 Mental health terms

Bio-medical terms can be like a different language and, as with any language, learning it can help us to understand what is happening. This section gives definitions and explanations about some of the language associated with children's mental health. There are many definitions for some of these terms.

Mental health: We all have mental health and, in a similar way to physical health, it can fluctuate in response to a range of factors. The World Health Organization defines mental health as:

> … a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.
>
> (World Health Organization, 2014)

If we are not able to cope with the stresses of life and can't do the things that make us feel we are achieving something positive, we can start to lack confidence and motivation. This is the same for children as it is for adults. Imagine being a child who is overwhelmed by events that are beyond their control, but must still attend school and be tested, or participate in activities that they have no motivation for.

Mental illness or a mental health condition: A disorder of the mind, which seriously affects a child's functioning as well as their behaviour or thinking over an extended period of time. There are a number of mental health conditions, the most common in children being depression, anxiety and trauma-related problems as well as issues to do with poor conduct. There will be more about these conditions later in the course.

Wellbeing: A concept that has many definitions, but is usually associated with being 'comfortable', happy, well-adjusted and healthy. Other definitions make reference to the quality of an individual's life. In relation to children, their level of wellbeing can often be judged in relation to their behaviour. A child who is experiencing a poor sense of wellbeing is more likely to be unhappy, have difficulty in concentrating and be unable to engage adequately with everyday activities.

Figure 9 Children's wellbeing is to do with the quality of their lives

Diagnosis: The identification of the nature of an illness or other problem by examination of the symptoms. Medical doctors are the professionals that usually diagnose mental health conditions, including among children. A diagnosis is helpful to enable a person to access appropriate and evidence-informed treatments, as well as for advocacy purposes (e.g. where parents who have a child with the same mental health condition can support

each other). However, a diagnosis is not always welcome, as unfortunately mental health conditions, even in children, can be stigmatised.

Developmental norms: A sound knowledge about developmental norms is essential in terms of 'making sense' of children and mental health conditions. For example, a young child that has an imaginary friend that they speak to in primary school is perfectly normal (and is thought to be associated with being intelligent), whereas talking to an imaginary friend for older teens is seen as unusual and often problematic. Hence, children with a mental health condition will present in ways that are outside of the norm, but determining what is within the 'normal range' is vital in terms of establishing if a problem is really a problem.

Risk factors: A risk factor in terms of child mental health is any attribute, characteristic or exposure of an individual that increases the likelihood of developing a condition. In relation to younger children, salient risk factors that can impact on their mental health include a clear lack of routine, not having their physical and emotional needs met, or living in a family where there is domestic violence.

Adverse Childhood Experiences (ACE): Stressful events that can occur in childhood including, but not limited to, the following:

- domestic violence
- parental abandonment (e.g. through an acrimonious separation or divorce)
- having a parent with a mental health condition where this is poorly supported
- abuse (physical, sexual and/or emotional)
- neglect (physical and/or emotional)
- growing up in a household in which there are adults experiencing alcohol and drug use problems.

Protective factors: Conditions or attributes in individuals, families, communities or wider society that mitigate or eliminate risk in families and communities, thereby increasing the health and wellbeing of children and families. For example, communities that have plenty of green open spaces and well-equipped schools are associated with enhanced health and wellbeing for children.

Nature and nurture: In the 'nature versus nurture' debate, 'nurture' refers to personal experiences 'growing up' and the impact of a person's context or environment. Nurture is therefore directly related to a person's childhood or upbringing. However, nature is to do with a person's biology, including their genes. A person's physical 'make up' (e.g. their potential to grow to a certain height) and aspects to do with their personality traits are determined by their genes. The person has little control over certain aspects or features of themselves, irrespective of where they were born or how they were raised. It is now generally accepted that children grow and develop as a result of a complex interplay between both nature and nurture.

Child and Adolescent Mental Health Services (CAMHS): CAMHS are a form of specialist mental health services, primarily delivered by the National Health Service in the UK. CAMHS provide a range of services for children and young people who have difficulties with their emotional or behavioural wellbeing. CAMHS vary depending on the catchment area they serve – with many having waiting lists, and struggling to meet the demands for their services.

5 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 6 Session 1 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do before the next session?

Provide your answer...

6 This session's quiz

Well done – you have reached the end of Session 1. You can now check what you've learned this session by taking the end-of-session quiz.

Session 1 practice quiz

Open the quiz in a new tab or window and come back here when you have finished.

7 Summary of Session 1

Now that you have completed this first session, you will hopefully have gained an overview of the history of children and mental health. You have also explored some of the reasons why there is an increase in awareness of children's mental health. Some of the language associated with mental health has been defined and you have started to identify factors that can impact children's mental health and wellbeing.

You should now be able to:

- describe an overview of the history of children and mental health
- outline reasons why there is an increase in awareness of children's mental health
- identify selected factors that can impact children's mental health and wellbeing.

In the next session, you will delve further into some of the causes of mental health conditions in children. You will also examine the possible impact of compromised mental health on children's development and education and explore some of the likely 'triggers' of anxiety in children.

You can now go to Session 2.

Session 2: Increasing your knowledge of mental healthUnit content

Introduction

It may be an obvious statement to make, but increasing your knowledge of the language relating to mental health can increase your understanding and, in turn, this can help to increase your confidence in supporting children's mental health. In this session, you will look at definitions of some of the mental health conditions that commonly affect young children. These include anxiety, depression, attention deficit hyperactivity disorder (ADHD), autism, phobias and behaviour disorders. Other pertinent issues, in particular school refusal and sleep problems, will also be explored. You will look at the impact of mental health issues on children's education and development, and identify some possible 'triggers' for children's anxiety in early childhood and school settings.

Now listen to the following audio in which Jackie Musgrave, one of the course authors, introduces the session.

Audio content is not available in this format.
Audio 1

By the end of this session, you will be able to:

- appreciate that children's mental health can vary for individuals and over time
- describe some of the common mental health conditions that affect children
- understand some of the factors that are associated with mental ill-health in children
- explore some of the effects of poor mental health and illness on children's education and development
- identify 'triggers' for anxiety in children.

1 Understanding children's mental health

In a similar way to our physical health, our mental health can go through sub-optimal periods and will not be as good as we would like. We can go through periods of time when

we seem to get 'every cold going', stomach bugs or simply feel 'off colour'. In a similar way, our mental health can be good, not so good or downright bad.

Figure 1 Understanding children and mental health

It may be helpful to think of mental health as being like a windscreen wiper: on one side mental health can be good, but it can move across to the opposite side where it is bad. There is a great deal that we can do to keep our mental health on the good side of the spectrum.

Figure 2 represents mental health as a spectrum, with good mental health on one end and poor on the other. In a similar way to a windscreen wiper, mental health is not static and it can move from one end of the spectrum to the other.

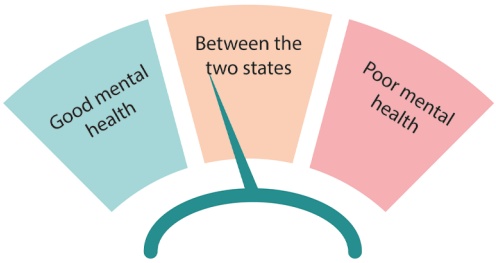


Figure 2 The windscreen wiper of mental health

In a similar way, there can be variability in children's mental health, meaning that it can vary between being 'good' (or ideal) or 'bad' (or compromised). However, there are significant differences between adults and children. For instance, very young children are likely to have less understanding about their feelings: they can find it difficult to clearly identify their emotions and they will not have the same vocabulary to describe their emotional state using words. For example, a young child's anxiety may manifest in physical form, whereby they have a 'funny feeling in their tummy' about a situation they are in (or anticipate they will soon be in). An adult is more likely to recognise the physical sensation they are experiencing (e.g. 'butterflies in your stomach') as a feature of an anxious state.

Figure 3 An anxious child

However, for a young child in an anxiety-inducing situation, it may be a challenge to understand the feelings they are experiencing, and to regulate their emotions so that they do not become overly distressed. For instance, for a very young child, the thought of being separated from a loved adult can cause 'a funny tummy feeling'. Also, it is likely that very young children will not have the vocabulary and language development to be able to articulate their thoughts and feelings. Very young children, in particular around the age of two, are likely to demonstrate their emotions, including anxiety, by displays of high emotion including crying, shouting and kicking; in other words, by having a tantrum straight after being separated from a loved one (also known as an attachment figure). These responses are not usually seen as majorly concerning for very young children, but the same sort of response in older children is usually a sign that could mean issues in terms of their mental health. If a child is frequently experiencing situations that cause anxiety which seems disproportionate to the event (e.g. a Year 5 student having a 'tantrum' every time they are dropped off at school), this is usually a sign that a 'problem is a problem' which is impacting on their general wellbeing. This older child is more likely to have compromised mental health and be at risk of developing a mental health condition which will require a professional assessment. Therefore, understanding children's behaviour for their age and stage of development is extremely important for all adults involved in the care and education of young children.

2 Understanding children's development

Think of a newborn baby. Imagine how small they are and how they rely on the adults around them for their physical and emotional needs to be met. Now fast forward to a baby's first birthday. Most will have tripled their birth weight, might be walking, able to communicate a range of their needs and will have developed their own personality. This first year of life is, for most children, a time of rapid growth and development.

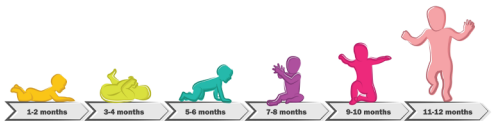


Figure 4 The growth of babies from birth to their first birthday

The term 'child development' is used to describe the expected changes that occur from birth and throughout childhood; the areas of development are described as physical, intellectual, language, emotional and social. The areas of development have been traditionally separated out in order to make the study of children and their development easier; however, realistically, the different areas overlap with each other. And the way that a child develops in each area can impact on their sense of wellbeing and, in turn, can influence whether their mental health is seen as 'good' or 'bad'.

Although the study of children and their development has identified a range of skills, growth, maturation or learning that a child is expected to have achieved by a certain age, it is not necessarily the case that each child will develop in the ways that psychological theories have outlined. There are many influences on children's development and, returning to the diagram you first saw in Session 1, the level of development will depend on the systems and resources around the child.

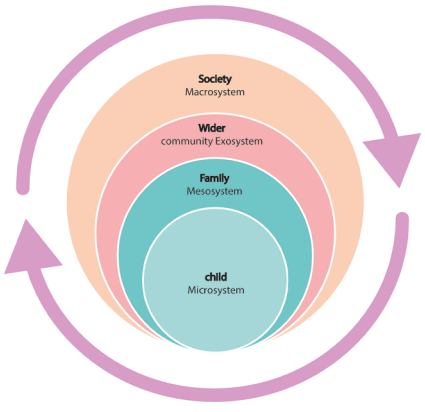


Figure 5 Systems around the child (adapted from Bronfenbrenner, 1979)

If a child is lacking the factors that make a positive contribution to their development, this can mean that a child may not meet the expected norms of development. On the other hand, if children have access to many of the positive influences on development, some children will exceed the expected norms. However, despite the systems around them and

the resources available to them, some children can still experience compromised mental health.

Gaining an understanding of how children develop is important because it helps adults to understand the expected behaviours and abilities for a child at a certain age. For example, an eight-month-old baby is likely to feel very anxious about the prospect of being separated from their main carer or attachment figure and they are likely to show their distress by becoming clingy and crying. As children grow and develop, they will learn that their main carer will return, so even if they are not completely happy about being separated they can be reassured more quickly and easily when separated.

There is a great deal that adults can and should do to prepare children for transitions between home and care and education settings; you will focus on this in Session 5. If, despite careful preparation and attention to the child's needs, a child exhibits behaviour that is not typical for their stage of development, this may be an indication that something is amiss.

Understanding the expected norms of development can be helpful, but it is also important to understand that each child is unique and will develop in their own way and in their own time. However, knowing the child's 'unique ways', their general behaviour, development and preferences is helpful so that any concerning changes that last for an extended period can be identified and addressed.

3 Knowledge of mental health

As you've already seen, children's mental health can fluctuate. While there is much that can be done to support and improve children's wellbeing and mental health, some children will develop a diagnosable mental illness. In the following sections, you will look at some of the common mental health conditions that can affect young children.

3.1 Definitions of specific, common mental health conditions or issues affecting young children

This section gives some definitions of mental health conditions that most commonly affect young children:

Anxiety: A feeling that can cause overwhelming emotions, nervousness and sometimes fear.

Figure 6 An anxious child being comforted

Anxiety may develop because a child is predisposed to being anxious, or it can develop as a consequence of adverse experiences. Anxiety can cause physical symptoms, such as 'butterflies' in the tummy, or what children may describe as 'funny feelings in my tummy'. Children may become breathless and panicky, which can result in a panic attack. Very young children can experience anxiety related to a range of triggers such as a food phobia, being in an enclosed space or issues to do with going to the toilet. Some children can develop ongoing anxiety that becomes so overwhelming that they find it difficult to lead their lives. Treatment for very young children is unlikely to be medication and more likely to be psychotherapeutic approaches such as talk-based treatments, like cognitive behavioural therapy (CBT).

Attention deficit hyperactivity disorder (ADHD): A neurological disorder that causes poor concentration, hyperactivity and impulsive behaviour (Burton, Pavord and Williams, 2014). It is worth mentioning that these signs can be present in a child, but may not meet the threshold to be diagnosed with ADHD. However, frequent persistence of the aforementioned features which has a considerable impact on the child's functioning, and where the issues are present across a range of environments (in particular school and home) is suggestive of ADHD. Treatment of this condition includes medication and psycho-social interventions. It is also extremely important that there is support for parents and professionals, in particular the child's teacher, to understand and adequately assist

children with ADHD. It is also important to avoid being overly negative or punitive in response to behaviour that is extremely difficult for the child to manage (e.g. fidgeting) and instead to develop positive approaches that channel the energy and enthusiasm that many children with ADHD exhibit.

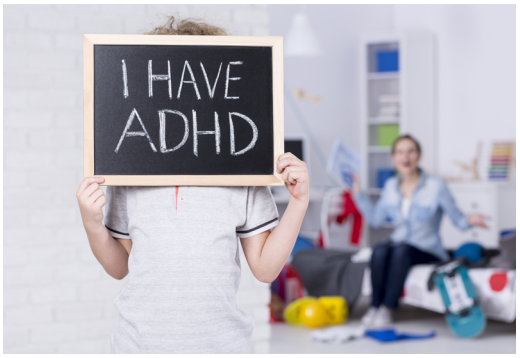


Figure 7 'I have ADHD'

Autism spectrum disorders: Autism is a complex condition that is more common in boys. The symptoms can be relatively mild but, as the name suggests, because the symptoms go across a spectrum, they can also affect children in ways that are more noticeable and severe. Autism can impact all areas of children's development in small or profound ways. In particular, children with autism can struggle in areas relating to social and communication development and may find it difficult to understand certain social situations. Children with this condition can become especially focused, often to the point of obsession, with certain play activities. They can also become fixated about particular foods, smells and sensations associated with certain objects.

For more information about autism, look at the free Open University course *Understanding autism*.

Figure 8 Understanding autism

Behaviour disorders: These refer to children's behaviour that is related to extremes of the norms, meaning that children can be especially disruptive, destructive and/or aggressive to the point of being persistently anti-social. Two of the most commonly occurring conditions are conduct disorder and oppositional defiant disorder. Behaviour disorders can be accompanied (also known as being 'comorbid') by other conditions such as anxiety and ADHD. As with autism, behaviour disorders are more common in boys.

Depression: Depression and depressive disorders can affect a wide range of people, including children. It is characterised by protracted low mood and impaired functioning, which can lead to a reduction in activity, reduced motivation and challenges in experiencing everyday pleasures. Diagnosing depression in children can be challenging

because many of the symptoms or features that affect adults with depression, such as repeated crying, sleep disturbance and lack of appetite, are common problems in childhood. If such symptoms carry on, along with impact on functioning and persistent sadness over a period of time, this may indicate that a child is depressed. Rates of depression are fairly low for children before puberty.

Enuresis and encopresis: Enuresis is bladder incontinence and encopresis is faecal soiling that persists beyond the age when it would normally be expected that a child would have gained control over their bladder and bowel function. It is important that physical causes are eliminated before considering that there are psychological reasons for incontinence (and it is important to remember that night-time bedwetting is not unusual in children even when they are at primary school). Bedwetting at night, or nocturnal enuresis, can be managed by behavioural therapy; for instance, by using an alarm pad that is activated when the child starts to pass urine. Encopresis can sometimes be linked to a child's anxiety about passing faeces as a consequence of embarrassment or limited toilet training.

Phobias: These can be described as an extreme fear of something that causes great distress and anxiety. Phobias can be specific, such as agoraphobia, 'a fear of open spaces'. Phobia-inducing objects can range from obvious sources such as snakes and spiders to balloons, germs and even clowns. Cognitive behavioural therapy is a frequently employed and effective form of treatment for phobias.

Figure 9 A child with a phobia of spiders

School refusal: Children can develop extreme anxiety about going to school and there can be a wide range of reasons why they are refusing to attend. In some cases, children can become phobic about attending school; this is usually a symptom of an underlying cause. Examples of such causes include bullying, anxiety about separation and being away from home or inability to cope with academic expectations. Careful exploration of the underlying reasons and close collaboration with school staff is needed to identify the issues.

Sleep disorders: Sleep is essential for all people; however, it is especially important that young children have adequate amounts of sleep. This is important for physical growth and development as well as for good mental health. Some young children will be easy to settle and are 'good sleepers' (and eaters too), while others will take longer to fall asleep and will wake more often. Young children require long periods of sleep and naps (for young children) during the day; the amount of sleep needed can be under-estimated by adults and children can become sleep-deprived. It is especially important that young children have a routine that allows time for them to wind down and relax in preparation for sleep.

Figure 10 A child relaxing before bed

Of course, establishing good sleep routines can be easier said than done, and there are many reasons why young children can develop issues to do with sleep. Identifying how and why a child has developed a pattern of interrupted sleep can be a little like working out whether the chicken or the egg came first, because if a child is developing anxiety about something, this can prevent them from sleeping. Lack of sleep will exacerbate how children feel and impact on their wellbeing and in turn, can be a cause of poor mental health. Plus, some children will just find it easier to sleep, as is the case with adults too. As you will explore further in Session 8, time spent on over-stimulating electronic devices and social media later at night can also have a negative impact on children's sleep patterns.

4 The impact of physical health on mental health

In the previous section, you explored some of the common conditions that can affect young children's mental health. However, children's mental health can also be impacted by their physical health. For example, children are increasingly being diagnosed with chronic (meaning that they are ongoing) health conditions (World Health Organisation, 2020). The most common chronic conditions that affect young children in high income countries include asthma, diabetes and eczema. As many as 10–15% of children have asthma (NHS England, n.d.), which means that between 3 and 5 children in a class of 30 are likely to have asthma. Eczema is thought to affect 11% of young children and the number of children with Type 1 and Type 2 diabetes is also increasing.

Chronic conditions can have a profound impact on children's lives; for instance, they may have dietary restrictions, or they may need to use inhalers or other medications, such as injections, to manage the symptoms. The symptoms of chronic conditions can set a child 'apart' from their peers, be painful and unpleasant, and, in some cases, life-threatening. For example, asthma attacks are still a cause of child deaths in the UK. It is not surprising that the presence of a chronic condition can be a source of great anxiety to a child (and their family) with one or more chronic conditions. It is not unusual for children to have a combination of chronic conditions; asthma, eczema and allergies are all conditions that frequently affect children. Physical conditions can have profound psychological consequences and sometimes there can be a range of interrelated symptoms that can create a complex picture in terms of a child's overall health and wellbeing.

Activity 1 The possible impact of chronic health conditions

Allow about 15 minutes

Read the following case study about Charlotte: her experience is based on a child taught by the author of this course. As you read it, consider the following questions:

1. What are the possible effects of Charlotte's chronic physical health conditions on her mental health and wellbeing?
2. How could adults support Charlotte to improve her physical health and wellbeing?

Case study: Charlotte

Charlotte is 6 and she has had eczema since she was 5 months old. The eczema has been widespread and she has large patches of 'angry-looking' skin, which is red, inflamed and weeps fluid. The itchiness causes her to scratch relentlessly, to the extent that she causes herself to bleed. Despite her mother's diligent application of creams and avoidance of many of the known triggers that provoke Charlotte's eczema, it continues to be troublesome and it is having a profound impact on many aspects of her life as well as her family's life. For instance, night times have always been difficult: Charlotte's sleep has been affected by eczema because she has an almost continuous need to scratch.

Figure 11 A child with eczema

As well as having eczema, Charlotte has recently been diagnosed with asthma. Before the diagnosis, she was coughing at night, which meant she was waking frequently; this also impacted on her sleep pattern. Asthma symptoms also affect Charlotte during the day; because she is short of breath, she finds it uncomfortable to run around outside and play with her friends, so she finds it easier to walk around with the teacher during playtime instead.

Furthermore, Charlotte is going through a period where her eczema is particularly troublesome. Her hands are especially affected with dry crusts that are prone to bleeding. Some of the children have noticed the blood and are starting to make comments that are very hurtful to Charlotte. Because of the children's comments, Charlotte has started to be excluded from playtime activities. She has also realised that she is not being invited to birthday parties.

In addition to the social exclusion, Charlotte's lack of sleep means she is always tired during the day. This means she is irritable with her friends, as well as finding it difficult to concentrate, so she is also struggling to keep up with her schoolwork. Her asthma is especially bad during the early summer when hayfever is at its worst; taking part in Physical Education (PE) and school events such as sports day is difficult for Charlotte. Consequently, she is not able to have many opportunities to exercise and to benefit from taking part in physical activity, which is important for a child's wellbeing.

Provide your answer...

Discussion

Charlotte's story is not unusual: asthma and eczema are conditions that often go together (i.e. are comorbid). The symptoms, such as the itchiness that eczema causes, can be very troublesome. Also, because her skin is so affected, the condition is very visible. Such visibility can cause distress to the child and, sadly, it can be a cause of social exclusion, as in Charlotte's case.

In the same way that adults have a responsibility to teach children about tolerance and understanding in relation to race, colour, disability and class, there is also a responsibility to do the same in relation to other children's chronic health conditions.

In Charlotte's case, it may be helpful for her teacher to work with her mother and the school nurse (if one is available) to identify ways of improving her participation in school life. The school nurse is likely to be able to offer support to Charlotte and her mum in improving Charlotte's physical health; for example, by ensuring that she has

access to creams and other medication while she is at school, which in turn would improve her wellbeing and mental health.

5 The impact of mental health issues on children's education and development

In the following sections, you will explore the potential impact of mental health issues on children's development and how, in turn, mental health can affect their education.

You'll start by focusing on how mental health conditions can affect children's development.

5.1 The potential impact on children's development

The presence of a mental health condition can impact on children's development in a range of different ways. Anxiety can impact on children's social development because they can find it difficult to feel confident in interacting with other people. It can also impact on their speech and language development to the extent that they can become selectively mute, meaning that they will choose not to speak in certain places (or to certain people), usually when at school, but will do so when at home or on their own with one other trusted person. Anxiety and ADHD (in particular when inattention is a major feature) can reduce a child's ability to concentrate, which is likely to impact on a child's educational attainment.

5.2 The potential impact on children's behaviour

Children who are experiencing mental health problems, especially those which are considered 'externalising disorders' (such as oppositional defiant disorder) will have accompanying behaviour or 'conduct' problems. Disruptive behaviour can be the child's way of letting adults know that they are experiencing emotions that are overwhelming them. How adults respond to children's behaviour can help to defuse a situation where a child is displaying what may be regarded as unacceptable behaviour. However, when it comes to young children, there is not a 'one size fits all' approach. How we respond to a child's behaviour will depend on the child's age and stage of development and the adult's expectations around what is acceptable.

While there isn't a single approach to managing young children's challenging behaviour, there are some principles that should be taken into consideration when responding to a child's misbehaviour. Look at the behaviour management toolkit in Figure 12, which is a flowchart that illustrates the considerations that need to be taken into account.

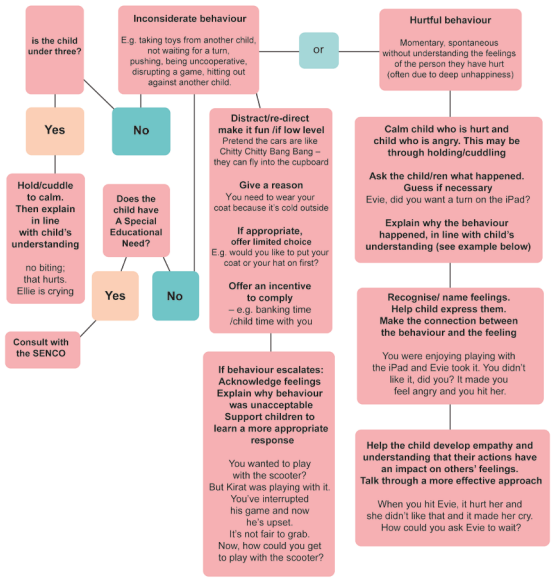


Figure 12 Understanding children's behaviour: a toolkit (Stobbs, 2019)

Activity 2 Managing the behaviour of children under 5

Allow about 15 minutes

Look at the following scenarios and use the behaviour management toolkit in Figure 12 to consider your response to how adults – that is, parents, practitioners, teachers or health visitors – can work with the children in each of the examples. Note: SENCO stands for Special Educational Needs Coordinator. They are specialist school teachers who support children with additional needs.

1. Mollie is 2. Having been an only child, she has recently had a new sister. Mollie has started biting other children at pre-school.
2. Arun is almost 5. Despite his parents and the practitioners in his setting using a consistent approach to managing his behaviour, he is proving very difficult to handle. He constantly interrupts when other people are speaking and disrupts other children's play, often violently.
3. Evan is 3 and a half and his mum has recently died. He used to be a very happy boy, but he has become deeply unhappy and displays his grief-related emotions by being aggressive and angry towards others.

Provide your answer...

Discussion

In your response, you may have considered the possibility that Mollie's behaviour has changed because she is feeling that she is getting less attention since her new sister has arrived. And she may have learned that biting someone is a very good way of getting attention. As outlined in the toolkit, holding and cuddling Mollie (rather than responding with anger), while explaining to her why she shouldn't bite, is the right response. Additional responses and processes are likely to be needed, to ensure the child who was bitten is supported and that Mollie is stopped from biting other children in the future.

Figure 13 Sibling rivalry

At almost 5, Arun is proving resistant to a calm and consistent approach to help support him to manage his behaviour. It may be that he has a mental health condition that is yet to be diagnosed, such as ADHD, that is affecting his behaviour. Although it is very important not to jump to conclusions, as a thorough professional assessment will be needed to confirm a diagnosis, it is important to observe Arun's behaviour to see if there are any clear triggers or obvious antecedents that occur immediately before the problematic behaviour. It would also be useful to discuss Arun with the setting's special educational needs coordinator (SENCO). The SENCO will have undertaken training to help support and guide practitioners to understand and manage children with problematic behaviour.

Evan is obviously responding to his bereavement and feelings of grief and loss, and it is often a human response to express such feelings by becoming angry. At 3 and a half, Evan's feelings will be further compounded by his lack of understanding about death. Evan will need validation, an empathetic approach and other social support to help him cope. Working with his remaining family and main carers will be needed. Evan will benefit from age-appropriate play opportunities and books that tackle the subject of loss and bereavement. There are charities that can help children who have experienced bereavement, such as Young Minds and Cruse.

5.3 The potential impact on children's education

Some very young children may have caused concern in relation to their social and emotional expression. As a result, they may have been assessed and their needs identified. However, for some children, prior to attending formal education, such needs may go unnoticed and it is not until they encounter group situations with multiple demands and expectations that problems start to become evident. Conversely, a number of children with significant mental health issues can go unrecognised for long periods after attending formal education because they are not a 'management problem' in the classroom or at home.

The more formal requirements of school may be a challenge to very young children who are at the early stages of developing peer-related social skills, which take time to develop. In addition, the expectations of school may be very different to those at home and an

inconsistent approach can be confusing for children. With careful management, such issues can often be resolved.

However, some children with problematic behaviours may find it significantly more difficult over time to initiate, establish and maintain healthy relationships with adults and/or peers. They are also likely to find it difficult to regulate their emotions.

Here are some of the indications that a child is experiencing difficulties in school:

- withdrawn behaviour
- challenging, overactive and/or disruptive behaviour
- tantrums and 'meltdowns'
- over-controlling behaviours
- panic attacks
- lack of attention and focus
- mind seeming to go blank
- irritability
- low mood
- low levels of energy
- extreme tiredness
- poor self-esteem
- lack of confidence
- little motivation
- increasing levels of anxiety
- feelings of insecurity
- mistrust
- avoidance of contact/emotional comfort
- school refusal.

Children will have their 'ups and downs' so it would not be particularly concerning for a child to experience some of these listed issues on any given day. However, when a child is experiencing several of these issues on a regular basis, and they are negatively impacting on their functioning, then a full assessment of their mental health is warranted. A child's SENCO can help in arranging for such an assessment, or a parent can request that the child's general practitioner refer the child for an assessment at the local CAMHS.

5.4 'Triggers' for children's anxiety in early childhood and school settings

In the following section, you will look at some of the situations that can trigger anxiety for children when they are in educational settings.

Transitions and changes of routine: For many young children, moving from their home environment to an educational setting for the first time can be challenging but exciting. For some children, however, the experience may be overwhelming and difficult to accomplish. For example, children who do not have a stable family life may not be able to cope with the demands and expectations that are placed on them when they start school.
Conversely, some children have a very supportive home and family environment and they

struggle with starting school. They may not feel as emotionally prepared for the change as some other children. Behaviour that is acceptable at home may not be in a more formal setting. If young children are better prepared for such discontinuities, and the different expectations between the two environments are more openly discussed between parents, children and school staff, then more effective bridges between home and school can be created.

Figure 14 Child making the transition from home to nursery

Children on the autistic spectrum may find changes to their normal routine problematic, as they will find it more difficult to feel they have a sense of control as to what is happening; consequently, starting school may 'unbalance' them. As a result, these children might increase some of their obsessive and/or repetitive behaviours as a way to block out the chaotic, unpredictable and 'noisy' environmental sounds and movements, as this can help them cope with the extra (unwanted) stimulation.

Both schools and carers have a responsibility to ensure that transitions happen as smoothly as they can, with good links made between home and school as early as possible. At times, for children with additional needs, these transitions require creative solutions (e.g. reduced hours to start with) and agile problem-solving (when things do not go as planned). Good practice to help children feel a greater sense of belonging and emotional security also highlights why the role of the key person in early years settings is so critical. You will look at this further in Session 5.

Bullying: Bullying, rejection from peers and teasing can be widespread wherever children engage in groups. It is not always easy for adults to understand the huge distress that bullying can cause children, especially when it involves what adults may see as low-level examples such as making fun of each other and intermittent teasing. However, when teasing becomes targeted and persistent, the child may feel extremely unhappy, especially when there is no escape from cruel and relentless judgements about themselves and the bullying goes unpunished. Thinking back to Session 1, where Bowlby's theory of attachment was introduced, you looked at attachment and how children build relationships. The importance of children developing close, caring and positive relationships helps them to build up an effective internal set of ideas, or what has been called an 'internal working model' (Bowlby, 1969) of how they see themselves. If children receive consistently negative messages, this can feed into a child's self-image of being less worthy and lead to them developing low self-esteem. The concept of internal working models will be looked at in detail in Session 3.

There are ways in which carers, schools and the local community can discourage bullying and encourage the growth of positive social relationships. You will look at this in more detail in Session 5.

Problems with the demands of school work: Even very young children can become frustrated, anxious or down if their attempts to meet the perceived standards of formal schooling (or what they think their parents want them to achieve) do not result in successful outcomes. They can then become so worried that 'fear of failure' stops them from completing work satisfactorily, or even 'having a go'.

Often, the fears that a child has built up are worse than the reality of the situation (i.e. the anticipation is worse than the actual event). Helping the child to separate their thoughts and feelings from other people's expectations can help. Also useful is working with the child to create achievable personal goals that they can monitor in some way themselves (e.g. using sticker charts).

Difficulties with teachers: In Session 3, you will explore how attachments between young children and significant carers evolve. Within these processes, teachers can be seen as potentially valuable secondary attachment figures as young children transition from home to school. However, sometimes children and teachers do not get on very well together and relationships can be strained or break down. In such circumstances, children might feel reluctant to go to school, develop psychosomatic illnesses (i.e. a mental health issue that manifests in physical form) to stay at home, growing highly anxious or becoming extra 'clingy' to parents/carers.

The key to resolving these issues is finding out from the child what it is about that particular teacher that is upsetting them, and seeing whether a more positive relationship can then be restored through negotiation between the family, teacher and child.

Figure 15 Child having difficulty with a teacher

Socialising or group work: For some shy and anxious children, being part of a large group can be extremely intimidating. There can be the fear of being 'shown up' in front of others; therefore, these children might avoid answering questions in class. There can also be high levels of anxiety around performing tasks, even within a smaller group, for fear of 'getting it wrong' or 'being made fun of'. Such anxiety is not just limited to the classroom but can be made even worse in a large playground situation at break times. The solution for some children is to walk around with the teaching assistant or teacher on duty and avoid taking part in games or activities with other children. Unless such social anxiety is tackled early on, and the child gradually supported to join in with other children using a step-by-step approach, then the avoidance can become so ingrained that any social situations can become extremely agonising as the child gets older.

6 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 3 Session 2 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do before the next session?

Provide your answer...

7 This session’s quiz

Well done – you have reached the end of Session 2. You can now check what you’ve learned this session by taking the end-of-session quiz.

Session 2 practice quiz

Open the quiz in a new tab or window and come back here when you have finished.

8 Summary of Session 2

In this session, you've seen that a child's mental health will fluctuate, and that very young children have the added difficulty of their inexperience which may mean they are unable to recognise, articulate or make sense of their own feelings. Children's cognitive, social and emotional development is a process, just like any other aspect of their development. You've also seen that physical health conditions can have a detrimental impact on children's emotional wellbeing and mental health, as demonstrated in the case study of Charlotte.

You should now be able to:

- appreciate that children's mental health can vary for individuals and over time
- describe some of the common mental health conditions that affect children
- understand some of the factors that are associated with mental ill-health in children
- explore some of the effects of poor mental health and illness on children's education and development
- identify 'triggers' for anxiety in children.

In the next session, you will look at the 'ingredients' of good mental health and wellbeing for young children.

You can now go to Session 3.

Session 3: Mental health promotion and educationUnit content

Introduction

On one hand, there are many complexities surrounding our understanding of children's mental health and appreciating the reasons why a number of children are experiencing poor wellbeing and compromised mental health. On the other hand, it may also be helpful to recognise that there is a great deal that adults can do to improve children's wellbeing, promote good mental health and consequently prevent serious and enduring mental health conditions in young children.

In this session, you will explore what is meant by 'mental health promotion' and how improvements in terms of education and understanding in relation to mental health can help us to support and promote mental wellbeing in children. You will also explore the foundations of 'good mental health', and the theories that underpin current beliefs and approaches.

Now listen to the audio introduction to this session.

Audio content is not available in this format.
Audio 1

By the end of this session, you will be able to:

- understand what is meant by mental health promotion and education
- explore some of the key ingredients of 'good' mental health in young children
- reflect on the main components of attachment theory
- consider the effects of attachment relationships on young children's mental health and wellbeing
- examine ways to prevent and minimise the impact of adverse childhood experiences (ACEs)
- have an awareness of how perseverance and resilience can be promoted in the early years.

1 Understanding mental health promotion and education

Health promotion in relation to physical health has been recognised as a powerful way of potentially preventing health conditions and diseases.

Figure 1 Prevention is better than cure

Preventing the causes of illnesses such as infections, heart disease and cancer is, as the old saying goes, 'better than cure'. Health promotion requires people to be educated about the causes of health conditions so that they can learn how to adapt their behaviours in order to decrease their risk of developing a condition. In a similar way to promoting physical health, mental health can also be promoted.

1.1 Mental health promotion

Messages about promoting health through exercise, healthy eating and avoiding high risk activities such as smoking are very actively promoted, from bus stop posters to national advertising campaigns, and hence are part of everyday life. In a similar way to promoting physical health, there are many activities that can promote mental health. These include:

- reducing and adaptively managing stress
- engaging in enjoyable activities and hobbies that increase our wellbeing, such as walking
- developing and maintaining positive relationships with people
- getting sufficient sleep.

Adults can more easily make a conscious decision about their readiness to engage in activities that promote their physical and mental health; in fact, some activities are equally beneficial for both aspects of health. Engaging in such activities can prevent, or at least reduce the chances of developing health problems such as heart disease, diabetes and certain mental health conditions.

1.2 Promoting mental health among children

To some extent, adults have a choice about whether they accept the health promotion messages that surround us. This is not to say that 'choosing' to follow a 'healthy way of life' that contributes to the prevention of some illnesses is straightforward. Far from it. The business of life – in particular personal circumstances and where we live – can make it difficult or even impossible to afford taking up a hobby, or being able to relax and go for a walk in a safe environment. However, most adults will have some level of control over their health-promoting behaviours, and even though it may be difficult to make certain changes, there is often some scope to do so.

For young children, their choices about what they can do to shape their lives in ways that maximise their physical and mental health are rather limited. Young children may not have the vocabulary to recognise and express their feelings, so emotional responses to situations can be expressed as 'bad behaviour', when in reality, the child is expressing their emotions, which may include feelings of frustration, sadness or anger, in a way that is expected at their age and stage of development. Young children also have very little control in relation to where they live, who they live with and, often, considerable restrictions about what they do. Consequently, the adults in children's lives play a critical role in creating environments for children that are positive for their mental health. However, there is much to do to enhance people's understanding of how this can be achieved.

1.3 Health education about young children's mental health

During recent years, there has been growing awareness of the importance of addressing the mental health needs of adolescents, especially when they are presenting during a mental health crisis. As the twenty-first century has progressed, greater attention has been given to young children's mental health, including infant mental health. The national curriculum in many countries has included statutory guidance about school-aged children's personal, social, health and emotional aspects of education and development. This is an important part of the education of professionals and children about good mental health and you will explore this further in Session 5. However, there is still a need to develop messages that help to educate adults about young children's mental health and this is especially so in relation to babies and very young children.

Several initiatives have been created to promote awareness and educate adults about the importance of infant mental health. For instance, in England, the charity Parent Infant Partnership UK was set up in 2012 and does extensive work to educate and increase awareness of the role of parents, professionals and society in developing good mental health for babies. The website has a great deal of useful information: a link is provided in the 'Further reading' section at the end of this session. Similar initiatives are also in place in Australia and the United States; for example, Zero to Three (a link is provided in the 'Further reading'). You will explore the global concern of young children's mental health further in Session 4.

So, what are the ingredients that contribute to the development of good mental health in babies and young children? You will focus on this in the next section.

2 The 'ingredients' of good mental health and wellbeing in young children

Sigmund Freud (1856–1939) is regarded as a pioneer in advancing knowledge of the significance of relationships in early childhood and what supports the development of good mental health across the lifespan. Freud was working in the late part of the nineteenth and first part of the twentieth century. This illustrates how recently the theories and research have been conducted that inform our knowledge of what humans need to promote good mental health. Freud's work was considered pioneering because the origins of current understanding and practice can be traced back to him (you will explore this further in the next session).

Part of Freud's legacy was his belief that early childhood experiences 'shape us' and are fundamental to determining what is likely to happen in later life. In the next section, you'll look at the 'ingredients' for good mental health in childhood.

2.1 A recipe for good mental health

It might be helpful to regard the factors that contribute to good mental health in childhood as a recipe. This analogy is useful because a recipe gives a list of ingredients and instructions on how to prepare something to eat. As we all know, recipes can be slightly different, depending on which cookbook or website you use. Likewise, the context of a child's life may require different ingredients, as well as some creative problem solving (like 'substitution') should an ingredient not be available. But even when we use the ingredients and follow the instructions, sometimes the results can be unexpected for a range of reasons, either in a good or not so good way.

Figure 2 A recipe for good mental health

Activity 1 What are the ingredients of good mental health for babies and young children?

Allow about 10 minutes

Reflecting on what you already know and what you have learned in the course so far, write a list of the ingredients that you think are likely to be a 'recipe' for good mental health for babies and very young children.

Provide your answer...

Discussion

When compiling your list of ingredients for good mental health and wellbeing, you may have included some of the factors from Session 1, Activity 2, such as resources within the child, family, community and society. You may have added ‘love’ as a key ingredient, but how would you quantify that? In particular, what actions or behaviours would indicate to a child that they are loved? It may be helpful to look back at your response to this activity.

However, as the course has progressed, you may also have increased your knowledge about the role of adults in promoting the mental health of young children. An important way that this can be achieved is for the adult to understand children’s development, and to be aware that some unacceptable behaviour can simply be quite typical of the child’s age or stage of development (e.g. tantrums).

One ingredient stands out as being the foundation of good mental health: the early formation of a stable, containing, unconditional and positive relationship. This assertion is based on the theory of attachment. In the next section, you will explore the theory of attachment and why it is so important in helping our understanding of young children’s mental health.

2.2 Attachment theory: what is attachment?

When explaining the original theory of attachment, psychologists and others have suggested that babies are born with a biological need to be physically close to an adult for survival and protection. They are therefore very dependent on significant adults being both physically and emotionally available to take care of them. These early relationships with adults shape the way children learn to trust others, as well as their understanding of how relationships work and their feelings about themselves. The basic need for young infants to feel safe and secure which encourages closeness with adults can lead to a range of behaviours that foster closeness, such as smiling and cuddling attachment figures. Other behaviours like crying and being clingy can also occur when an infant becomes distressed, and it is usually the primary attachment figure that can soothe the child. These are considered to be instinctive behaviours. Crying and becoming clingy can also be attempts to communicate an infant’s anxiety and distress when they fear separation (which is usually only for a short period).

Figure 3 Babies need to have physical and emotional closeness to caring adults

Activity 2 Understanding the continued need for attachment as adults

Allow about 10 minutes

In order to appreciate how we may feel emotionally more secure with some people rather than others, make a list of some of the main qualities that exist in people you trust and feel closest to.

Provide your answer...

Discussion

When you look back over your list of qualities it would be interesting to reflect on how many of these revolved around communication, the way they respected your thoughts and feelings, and how well they listened to what you had to say without making too many judgments. In psychological terms such an approach, which is also the cornerstone of any counselling relationship, is called 'unconditional positive regard' (Rogers, 1951). In other words, the person is still positive towards you – warts and all! That does not mean they condone or agree with all your behaviours and attitudes. Rather, they are giving you time and an emotionally safe space to be yourself.

Many children who have not had the opportunity to develop close, responsive relationships in early childhood may not have experienced such unconditional positive regard or been accepted for who they are. They may therefore have never felt what it might be like to have their feelings validated or be comforted when distressed. They may never have felt sufficiently safe and secure enough to relax, play and learn in the same way as other children because they have not had a consistent and stable primary attachment figure.

2.3 Background to attachment theory

John Bowlby developed his attachment theory when working as a psychiatrist at the Tavistock Clinic in London in the 1950s. His work focused mostly on children who had been separated from their parents (particularly mothers) in early childhood due to circumstances such as prolonged hospital stays, or children who were living in residential institutions. It is important to set Bowlby's work in the UK within the time frame following the Second World War, when many children had lost parents or were temporarily separated from them. These issues were discussed in Session 1 and particularly in the case study of Sheila, the evacuee.

The reason why Bowlby's ideas were so groundbreaking was that for the first time the psychological and emotional wellbeing of young children was being placed 'centre stage'. Today it can be hard to realise that care settings did not consider such issues to be equally as important as children's physical health.

As a consequence of Bowlby's work, various policies and practices changed for the better, such as hospitals allowing parents to visit their sick children, which today is taken for granted. There was also a greater emphasis on examining the quality of relationships between adults and children in institutional settings, which is now seen as a key indicator of how well an early years setting is functioning.

Since Bowlby’s original work, there has been a great deal of controversy around some of the statements he made in relation to the role of mothers as the main caregivers. He did not fully appreciate the wider family and care network that a young child might have. For example, some children are not raised by their mothers and are ‘perfectly well adjusted’, because other adults have been their primary caregivers and attachment figures. Originally, he stressed the need for mothers, as significant carers, to stay at home in the early years of a child’s life in order to avoid the development of future mental and emotional problems.

Figure 4 Women working in a factory during the Second World War

Even today there are many different opinions that arise about the extent to which significant carers should remain at home in the early years of a child’s development, and also the age at which young children should attend more formal early years settings. Despite the debates around Bowlby’s work, it is still significant and continues to influence our understanding of the importance of attachments for children’s social and emotional development.

2.4 The importance of attachment theory

Attachment continues to be an important psychological idea that helps to describe the quality of the relationship between the child and key caregivers in a variety of different care settings.

The most effective way to visualise attachment is as a process. Through the development of close, caring and positive relationships in childhood, a young child can build up an effective internal set of ideas or what has been called an ‘internal working model’ (Bowlby, 1969) of how they see themselves, how they interact with others, and also how they develop their own sense of who they are and who they can become within the social world around them.

Figure 5 is a diagram showing the interconnections between self, other and the world in order for the young child to build up an internal working model of how relationships work.

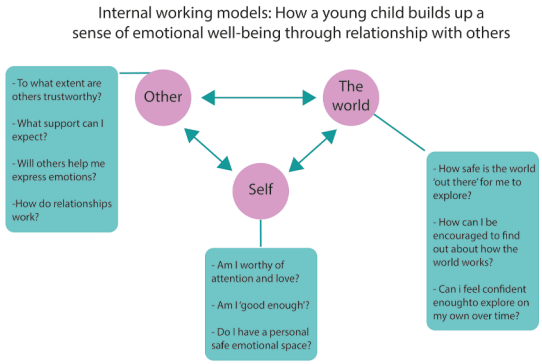


Figure 5 Internal Working Model (Bowlby, 1969)

Reflecting on the diagram and the questions that might be asked or addressed through different interactions, you might notice how different ways of being attached or connected to significant others, especially as a young child, will have an enormous effect on that child's perceptions. The components and quality of the different interactions will not only affect how the child perceives themselves and their own value in the world, but also whether they believe they are 'worthy' of affection and care from others.

Therefore, a young child who has experienced consistent and warm, loving connections with significant caregivers who have been attuned to their emotional needs will have been given 'positive acceptance' for who they are. They are then more likely to grow up feeling they are 'worthy' in terms of long-term relationships, in particular intimate relationships, and will be able to express their emotions more openly. They are also better prepared to make positive contributions to relationships with others in the future. The emotional security they experienced as a child is likely to lead to a greater understanding of a range of emotional reactions to different situations. Infants that are securely attached are not only more likely to have greater empathy for others, but also higher tolerance of being left alone for longer periods of time, away from significant others.

2.5 Emotional containment

Emotional strength involves the ability to express and accept a range of different emotions that might be experienced in a variety of circumstances. A child's emotional wellbeing can be influenced by the ways in which their feelings are accepted by significant adults in their lives. This process of accepting emotions, being able to hold them, is called emotional containment.

For example, if emotions such as anger are perceived by the adult to be almost exclusively inappropriate or undesirable, then a child may well learn to avoid adequately expressing such feelings. For example, many girls are actively discouraged even from a young age to express their anger (as this is not 'ladylike'). Conversely, many boys are actively discouraged from expressing feelings of sadness (because 'boys don't cry'). However, such habitual avoidance could build up greater frustrations and even lead to lower levels of emotional resilience or alternative forms of emotional expression (e.g. a boy's angry outburst when the underlying emotion is sadness).

In contrast, parents and carers who are able to adequately contain children's emotions and facilitate their emotional regulation (even when these can be difficult to tolerate at times) can help to nurture qualities such as emotional resilience. Adults can also help the

child to see that even when they are angry, upset or frustrated, they will be heard and validated.

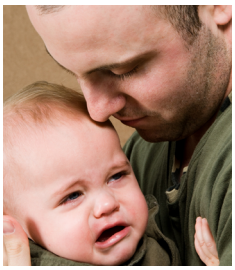


Figure 6 A father soothing his baby

Furthermore, contrary to what might seem like a natural instinct to ‘take over the situation’ in order to protect the child, all that might be necessary is for the adult to patiently take the role of an alert observer, actively watching and listening to what the young child is attempting to express. Ultimately, all behaviour – however challenging at times – can be seen as an attempt at communication of some kind; finding out what the child might be distressed about is key to helping them to develop greater emotional resilience.

Sometimes adults feel they need to ask a range of questions and they can have an ‘intense interaction’ with a child in order to find out what the problem is or how best they can help. Such strategies can often be extremely intimidating for the child. A more non-intrusive way can be through play or other joint fun/social interaction, which can help to diffuse or lessen anxieties – as long as the child feels ready to engage. Through such activities, the adult can help the child make sense of how they are feeling, even if they do not yet have the vocabulary to describe this using words. Both adult and child can then work together to negotiate ways to react differently to similar situations in the future.

3 The effects of attachment relationships on young children's mental health and wellbeing

In relation to attachment theory, the quality of the relationship between the caregiver and young child can influence how perceptions and ideas are built up over time by the child. These ideas then form the basis of how to respond in future social relationships. If they have experienced positive, warm and loving early care, they are more likely to feel secure and worthy of love and attention from others – and be able to give others love and attention. However, experiences of being perceived to be unloved and/or rejected could lead to a child avoiding contact with both adults and other children. Excessive anger and confusion in early childhood could create a greater resistance in the child as they may become increasingly anxious and unclear about what adults and others expect of them, or whether other people can even be trusted or not.

Activity 3 What can influence the development of secure attachments?

Allow about 15 minutes

Jot down at least three different influences on early childcare that might have a negative impact on a child developing a secure attachment relationship.

Then think of three influences that might lessen these negative impacts.

Provide your answer...

Discussion

In terms of negative influences, you may have considered the poor mental or physical health of the carer. For example, depression or chronic illness could mean that carers may struggle to be emotionally available and responsive to the child. Parenting styles are also thought to be very important, whereby neglectful (characterised by uninvolved and disinterested parenting) and authoritarian (parenting with limited affection and harsh punishments) styles of parenting are associated with insecure attachments

However, if the carer has a good support network, caring for the child can be shared with other members, allowing more opportunity for the child to develop a wider variety of positive 'internal working models' around how relationships work. That is because a child can have multiple attachment figures, and an attachment figure that adopts an authoritative style (i.e. care that is responsive to the child's emotional needs and also sets high standards for the child) for a child means that they are still likely to develop a secure attachment.

You will explore adverse childhood experiences in more detail later in this session.

3.1 Transitioning from home to other early years settings

The quality and nature of relationships that young children develop with significant others in the early years can help or hinder the ways in which they then cope with day-to-day changes in their routine and being away from home, as well as longer-term transitions from home to other early years settings. It is also important to remember that even securely attached toddlers can be affected if they are in a daycare provision where the quality of sensitive responsivity and attunement to the child's wishes, views and how they express themselves leaves much to be desired.

You will explore the creation of environments that are conducive to supporting early transitions as effectively as possible in Session 5.

Activity 4 Attachment and transition to daycare provision

Allow about 15 minutes

Read the following case study, which is based on a child that the author of this course has worked with, and then reflect on the questions that follow.

Case study: Danii

Danii, who is 3 years old, is looked after by her mother and her grandmother ('nan'). Her parents separated when she was 2 years old. Her mother then had to increase the number of hours she works in order to enable the family to continue renting their current accommodation, pay the bills and buy food and clothing. Danii then spent a great deal of her day in the care of her nan and grandfather ('gramps'). She was very fond of her gramps, but he died recently.

Danii is loved and well cared for and, whenever possible, given plenty of positive attention. As the only child, she is often in the company of adults and some of the older children in the wider family network who treat her as their adored 'baby' girl. However, she has not had much opportunity to spend time with other children her own age.

Danii's grandmother is beginning to have various health problems. On the advice of a GP and the health visitor, Danii is now to attend an early years daycare provision for three mornings a week to see how she gets on.

The first morning was very challenging for her grandmother; Danii would not leave her side at all, clinging to her and seeming to be very anxious and afraid. She also turned away from staff whenever they gently attempted to interact with her. Eventually, her nan said she had to go shopping, but would be back very soon to take Danii home. However, Danii would not go to any of the daycare staff or towards any of the toys once her nan had left. She ran and hid under a table and started to cry inconsolably, saying she wanted to go home.

- How do you think Danii's responses can be explained through attachment relationships she has developed so far?
- Imagine you are a member of staff: what do you think your next move might be?

Provide your answer...

Discussion

You probably reflected on the close relationship that Danii had already built up with both her grandmother and grandfather. You might also have put yourself in Danii's shoes, imagining how she felt going to a strange place for the first time. She was perhaps fearful about leaving her nan, bearing in mind that she has only recently lost another significant person in her life – her grandfather ('gramps'). Her clinging to her grandmother for so long highlights how, although feeling secure with her nan, she is not confident enough at this point to explore new places and interact with new people, even with her grandmother in close proximity.

In running to hide under the table, Danii was perhaps attempting to find a safe place where she would not be disturbed and have time to be on her own. Of note, given her young age, and very limited experiences of being cared for by people outside her family, her response is perhaps less pathological or extreme than you might think. It is not unusual for a 3 year old to find a transition like this difficult, although Danii's responses here do require careful monitoring.

So, what actually happened next? The staff did not immediately go to Danii and intrude in her space or attempt to physically comfort her. All such actions she may well have found very intimidating. Instead, one member of staff (who later became Danii's key person) sat near the table, on a level with Danii, gently handed her cushions and blankets so she could make up her own 'den', then quietly watched and waited for Danii's responses. In this way, Danii was being accepted as a child who could express her emotions and have control over what she then decided to do in her own time, without feeling pressured to meet external expectations or do things she did not want to do.

The case study of Danii illustrates how her key person helped to support Danii to make her feel better without overwhelming her. Danii had experienced a number of adverse experiences, but what are adverse childhood experiences? The next section explains more about what is meant by 'adverse childhood experiences' (ACEs).

4 Preventing and minimising the impact of adverse childhood experiences

There is no one definition of adverse childhood experiences (ACEs), although most attempts define the term as events in the early years of a child's life that may have a negative impact in childhood and adulthood. Michael Rutter described adverse experiences as 'the circumstances of early childhood that can cast a long shadow' (1998, p. 16).

Figure 7 Adverse Childhood Experiences

The next activity asks you to consider the experiences that children may be adversely affected by.

Activity 5 Identifying adverse childhood experiences

Allow about 15 minutes

1. List the experiences that may occur in childhood that you think could be considered as adverse.
2. Now watch the six-minute video below, made by the Wave Trust to explain ACEs and highlight how they can impact on childhood and into adulthood. The film is animated, but it does contain some information that may be upsetting. As you watch, consider your notes alongside the experiences mentioned in the video.

Video content is not available in this format.
Video 1 What are adverse childhood experiences (ACEs)

Provide your answer...

Discussion

The video highlights how a combination of family circumstances and behaviours, described as ACEs, can become a 'toxic mix' for children. You may have found the first two minutes of the video very negative, as if it is inevitable that there will be difficult long-term consequences for children who experience adverse childhood experiences. However, the second half highlights that this is not necessarily the case. The video shows that help in early childhood can avoid negative long-term consequences, noting that it is the responsibility of all professionals – such as teachers, police and health professionals – but most of all parents, to do what they can to support children and prevent them from experiencing ACEs. A primary function of parenting is to provide protection. In addition to shielding and protecting children from ACEs, it is also important to help children to develop resilience.

The next section explores how perseverance and resilience can be promoted in childhood.

5 Promoting perseverance and resilience

As with many psychological concepts, there is not a single definition of what is meant by ‘resilience’. The term should be viewed as more than the individual child’s ability to ‘bounce back’ from adverse or difficult circumstances. There are factors that support the development of resilience in children.

Figure 8 Developing resilience in children

5.1 Factors that support the development of resilience in children

The factors that can support the development of resilience in children can be examined by looking at the systems around the child, as illustrated in the diagram that you have already seen in Sessions 1 and 2.

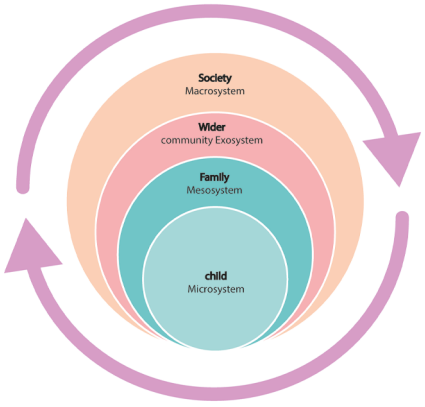


Figure 9 Systems around the child (adapted from Bronfenbrenner, 1979)

The following highlights some of the factors that can affect how resilience can develop within each of the systems, starting with the child.

The child

There are some factors that can help or hinder the development of resilience in children which are briefly described below:

Temperament: can be defined as the inborn traits that influence the child's approach to the world. If a child has an 'easy' and 'outgoing' temperament, they are perhaps more likely to quickly develop positive relationships. On the other hand, a child who is 'slow to warm up' and 'timid' may avoid social situations, struggle to develop peer relationships and play alone more frequently.

Health: a child with a 'strong constitution' may join in many physically challenging play experiences, both indoors and outdoors, so they will more easily develop their motor confidence and subsequently have more opportunities to develop resilience through the freedom to explore their environment. They will also feel more able to set themselves personal goals, achieve them and then extend their range of skills.

Disability: depending on the impairments experienced, a child with a disability may take longer than their peers to adjust to new situations or to learn new skills. For example, children with autism may have higher levels of anxiety in response to new social situations and their behaviour can be off-putting to other children, which can affect the development of peer relationships.

The family

Resilience in children can be fostered if the family or carers can provide a 'secure base' for children. A secure base means providing children with love and consistent routines. This facilitates emotional regulation, fosters learning opportunities, promotes social interaction and the development of friendships with other children.

The community

The wider resources that are available in the community can help children to promote resilience by providing opportunities to explore and play. For instance, playgrounds in the local community are an invaluable way of providing opportunities for children to play and explore and develop their social, emotional and physical skills.

Society

The status of children in the society they are growing up in is important in the development of resilience. If children's rights are recognised and upheld, it is more likely that they will be given opportunities to express themselves and make developmentally appropriate decisions about their lives. They can develop greater feelings of trust and become more resilient when faced with challenging circumstances. However, not all societies regard children as having rights. As you will explore in Session 4, childhood is perceived in different ways. These different perceptions impact on how children cope with adverse conditions and develop resilience.

6 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 6 Session 3 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do before the next session?

Provide your answer...

7 This session's quiz

Well done – you have reached the end of Session 3. You can now check what you've learned this session by taking the end-of-session quiz.

Session 3 practice quiz

Open the quiz in a new tab or window and come back here when you have finished.

8 Summary of Session 3

Now that you have completed this session, you will hopefully have gained an understanding as to why mental health promotion and education is important. You have also looked at the 'ingredients' of good mental health. You may now have a visual overview of the processes involved in attachment, and what is meant by emotional containment. The activities should have helped you to think about how early support can lessen the long term negative effects of adverse childhood experiences.

You have also started to explore early childhood transitions from home to other care settings and how these might be managed. You have also been introduced to the concept of resilience, and how the development of a child's resilience is affected by different interactions and influences within the different systems around the child that you first encountered in Session 1.

You should now be able to:

- understand what is meant by mental health promotion and education
- explore some of the key ingredients of 'good' mental health in young children
- reflect on the main components of attachment theory
- consider the effects of attachment relationships on young children's mental health and wellbeing
- examine ways to prevent and minimise the impact of adverse childhood experiences (ACEs)
- have an awareness of how perseverance and resilience can be promoted in the early years.

In the next session, you will focus on a more global view of children's mental health and wellbeing. You will consider how wider geographical, social, cultural, economic and political factors can have a huge impact on how children are perceived and also the lives children lead.

You can now go to Session 4.

Session 4: A global view of children's mental health and wellbeing

Introduction

Children's mental health is a global issue. Wherever children live in the world, there are factors and influences within their society that impact on their mental health. The COVID-19 pandemic of 2020 is an example of an event that has impacted on the physical and mental health of children and their families around the world. As you explored in Session 1, the systems around the child have a profound impact on their wellbeing and, in turn, this impacts on their mental health – for good or bad. For instance, the effects of war, conflict and the influence of economic factors mean that migration of people from country to country is an ongoing issue; without resolutions to the conflicts that are causing people to be displaced from their homes, this is likely to continue. The migration of people is often reported in the media; however, the impact of migration on children is under-reported.

In this session, you will examine children's wellbeing and mental health from a global perspective.

Now listen to the audio introduction to this session.

Audio content is not available in this format.
Audio 1

By the end of this session, you will be able to:

- form an overview of the impact of a country's geography and politics on children's wellbeing
- explore social, economic and cultural influences on children's wellbeing and mental health
- appreciate some of the effects of migration on children's wellbeing and mental health
- re-examine the role of resilience in helping children cope with difficult, dangerous and traumatic circumstances.

1 Influences and factors that can impact on children's wellbeing and mental health

Many factors can affect children's mental health. This includes where they live in the world, the politics of their home country, their family's economic status, and their social and cultural beliefs. Another significant factor that can impact on children's mental health is how the society in which they live regards their status and upholds their rights. In the following sections, you will explore each of these factors.

1.1 Geography

The connection between the geography of a country and the effect on children's mental health may not always be entirely obvious. However, the climate of a country can make the environment range from either 'hostile' to 'welcoming'. For example, in countries with extreme climates, such as some tropical countries, the climate predisposes the country to be the home of many diseases and parasites, both of which can negatively impact on children's health. This in turn can affect quality of life. The impact of disease and more extreme climates on long-term health and wellbeing is multifaceted and interconnected with poverty, access to medical care and clean water. All of this can impact negatively on wellbeing and predispose children to compromised mental health.

Natural disasters have also been shown to have an impact on children's mental health. Research following the earthquakes that affected New Zealand in 2010 and 2011 has shown that the stress experienced as a consequence of the aftermath impacted on children's mental health.

Figure 1 Damage to building in Christchurch earthquake

New Zealand media reported research findings showing that some children demonstrated behaviour disturbance and increased levels of anxiety and depression following the disasters (McCrone, 2014). There has also been a reported spike in adolescent suicides linked to the longer-term impact of the trauma experienced in earlier childhood because of the earthquakes. These examples highlight the link between geography and how the environment can impact on children's wellbeing. It is not surprising that children who live in geographically hostile environments or in countries which are prone to natural disasters can become anxious and develop mental health issues.

Extremes in climate and natural disasters are just two examples of how the geography of a country can impact on children's mental health and wellbeing. As you explored in

Session 1, how much can be done to reduce the impact of geographical factors on children's mental health and wellbeing will partly depend on the resources that are within the systems around the child.

1.2 Politics

The politics of a country can have a powerful influence on children's mental health. For example, children who live in low-income countries are less likely to have access to health services and an education beyond secondary school. The United Nations (UN) Sustainable Development Goals aim to improve the lives of all people in low-income countries and to 'address the global challenges we face, including those related to poverty, inequality, climate, environmental degradation, prosperity, and peace and justice' (UN, 2019).

There are 17 goals, which often overlap and interrelate.

Figure 2 Sustainable Development Goals

Goal 3 is related to good health and wellbeing. While there is no specific emphasis on children's mental health and wellbeing, improving health and reducing threats to health will, in turn, reduce the number of children who are orphaned (a major threat to a child's wellbeing), improving their mental health and wellbeing.

1.3 Economic influences

Living in chronic poverty often has a negative impact on children's mental health and wellbeing. In many parts of the world, especially in low-income countries, children are often relied on to make a significant material contribution to the family in ways that children in middle- and high-income countries are not expected to. As you will explore later in this session, children as young as seven may become part of the paid workforce in order to earn money to ensure their family's survival.

Figure 3 Children collecting water

In countries where water is scarce, it is often the responsibility of young girls to collect the water needed for cooking and drinking from a water hole, which often requires them to walk long distances every day. This in turn negatively impacts on their ability to get an education, because the priority is obtaining the water necessary for their family. The need for children to contribute in these ways is essential for the health and existence of the family; however, it often comes at a cost to children's mental health and wellbeing.

1.4 Social and cultural influences

The culture (or cultures) of any given society has a powerful influence on children's mental health and wellbeing. In some African cultures, it is believed that witchcraft is the cause of some medical conditions, for example epilepsy (Tedam, 2014). Meanwhile in Western countries, such as the UK, mental health conditions are still stigmatised, which is evident when people use diagnostic terms like schizophrenia in derogatory terms. Across the globe, there is gender inequality, and because of this inequality, girls often miss out on an education. In the USA, where there have been a number of mass shootings in schools, the so-called 'gun society' has had an impact on children's mental health (Currie, 2013).

1.5 The status of children

Where children live in the world has a significant influence on their mental health and wellbeing. However, in many countries and within many societies, the value and status of children across the world has changed considerably within the last 100 years.

According to Save the Children's (2017) Global Childhood Report, millions of children across the world have benefited from the many medical and technological advances that people living in higher income countries often take for granted. Children's overall wellbeing has improved as a result. These advances have included:

- development of, and greater access to, vaccines to prevent communicable childhood diseases
- better healthcare and support for mothers, children and their respective family networks
- more effective support for vulnerable children within their local communities via charities and other organisations in remote areas of the world
- efforts made by governments and other agencies across the world to help poorer countries become more economically self-sufficient

- increased access to clean water.

The first Declaration of the Rights of the Child was adopted by the League of Nations in 1924, inspired by Eglantyne Jebb, who founded Save the Children in 1919. This important declaration stressed various key rights for all children – such as the right to food, healthcare, education and protection from exploitation – which, at the time, were not seen as a priority in many policy-making decisions. Even though it was not a binding legal document, it meant there was a duty placed on the international community to put children's rights at the centre of all planning in matters that affected children's daily lived experiences. This was clearly a major shift in thinking.

The Convention on the Rights of the Child, subsequently adopted in 1989, has been approved by all but one nation (the US) (UNICEF, 2017). This Convention has had a further significant effect on the way that children are both viewed and treated. They are now viewed as human beings with their own independent set of rights, and sense of agency, instead of the passive recipients of adult care and charity.

The process of changing attitudes on a global scale has undoubtedly been slow. However, more nations and governments now value access to schooling for all children instead of accepting children toiling in fields and factories or living in vulnerable and unsanitary circumstances on the streets. There are now also more laws to prevent child labour and child marriage, and to make school free and available to all children, regardless of their gender, race, immigration status or special needs.

Activity 1 The UN Convention of the Rights of the Child

Allow about 15 minutes

Go to the UNICEF website and find out briefly what this organisation does.

Then scroll down a short way and either follow the link or use this link to read the summary of children's rights.

Clearly all the rights mentioned are extremely important; however, for the purpose of this activity, choose three particular rights and note down what you think these might mean in terms of adults supporting children in the daily experiences that they might encounter.

Provide your answer...

Discussion

As you read and follow through the activities in the next section 'Different childhoods', it would be useful to refer back to the articles within the UN Convention on the Rights of the Child and see how different practices are violating these fundamental rights.

2 Different childhoods

As you have already seen, the country and society that a child is born into can have a significant impact on their mental health and wellbeing. The following sections invite you to consider the lives of children who are experiencing childhoods that may be different from children living in a high-income country such as the UK.

2.1 Street children

Large numbers of children live on the streets of big cities and towns in countries such as India, Bangladesh and Ghana, where families are struggling to make ends meet.

Figure 4 Children living on the street

Children live on the streets for a number of reasons, such as:

- poverty – when a family is unable to afford to feed a child
- becoming orphaned
- running away from home because of abuse
- beliefs such as witchcraft where children are regarded as being possessed by evil spirits, which can bring bad luck to the family, so they are thrown out of the home.

Western countries like the UK also have issues to do with homelessness. For children, this is to do with poverty and other factors which lead to them becoming temporarily homeless (or in precarious housing situations). Older children in the UK, like children overseas, also run away from home. This is an ongoing issue for lesbian, gay, bisexual and transgender (LGBT+) youth, many of whom are 'coming out' while at school, due to hostile home environments.

Activity 2 Rescuing children from the streets of India

Allow about 15 minutes

The following video is 16 minutes long, but you could just watch the first five minutes for a glimpse into the reality of the lives of 'street children' and the challenges of offering appropriate support.

When you have finished watching the video, note down three issues that struck you as being particularly difficult for adults who might be attempting to help street children.

Video: Rescuing homeless children from the streets of India

Provide your answer...

Discussion

Children who have been forced to leave home and then need to learn how to survive on the streets are often labelled 'throwaway' children, which clearly gives the impression that they are unwanted, disposable items. Such children are also present in more prosperous societies. For example, there are at least 2.5 million children who are homeless in the US each year. That figure is equivalent to 1 in 30 children in the country (American Institutes for Research, 2014).

Quite often, street children have not completely broken all their family ties. They may be sending money home and visiting, even if on an irregular basis. Clearly, the longer these children remain living on the street, the more likely they are to experience poor physical and mental health. Street children are particularly vulnerable to exploitation and danger. In addition, their mental health is at risk because of the increased likelihood of becoming involved in consuming alcohol and/or drugs from a young age. Additionally, feelings of shame, rejection, loss and homesickness can impair their mental health.

Many children do somehow manage to survive living on the street by developing various coping strategies. Many children form groups or 'street gangs' that might offer more protection than they would have received at home. Gangs may become family substitutes and can even be organised in terms of the roles found in a conventional family, with all members respecting the 'rules' and older 'siblings' looking after younger children.

Figure 5 Gangs of children

Gangs can protect children against violence from other street children. They can also protect against police assaults and harassment, as well as the threat posed by members of the public who perceive street children as 'delinquents'. Gang members can also look after each other when they are ill or injured, therefore fulfilling some of their needs for love, a sense of belonging and emotional support. For more information about street children, see the Dundee University StreetInvest project: the link to the research is in the 'Further reading' section at the end of the session.

2.2 Child soldiers

In countries such as Sierra Leone, Afghanistan and the Philippines where there is or has been war or armed conflict, thousands of children have been forced to become soldiers.

Often, they are recruited as cheap labour and, because children often go 'under the radar' of adults, they can be useful spies.

Figure 6 A child soldier

However, as you'll see in the video in the next activity, they are also trained to kill. In civil war, this may involve attacking people within their own communities.

Activity 3 Experiences of a child soldier

Allow about 15 minutes

Watch the following short video from Unicef, which recounts the experience of James, who was taken to be a child soldier. James' story is presented as an animation, but you may find the content upsetting.

Video: James – a boy soldier

Now consider the following questions:

1. Do you think James had a choice about becoming a soldier?
2. Can you try to imagine the feelings he experienced while shooting at people in his own village?
3. After he returned to his village, what do you think the impact of being a soldier will have had on James, his family and the people in his village?

Provide your answer...

Discussion

You may have decided that James did not have a choice about becoming a child soldier: he would have been shot if he didn't cooperate, and there would have been repercussions on his family. The feelings that James would have had when he was forced to shoot his own friends, neighbours and even his own family are difficult to imagine, but again, he had little choice.

James had a terrible experience, but he was lucky to have been rescued and returned to his village. The immediate euphoria of being reunited with his family may soon have been replaced by feelings of guilt over what he had been forced to do in order to survive. James may have felt that he no longer belonged to his village in the same way that he did before he became a child soldier. Perhaps the villagers blamed him for some of his actions rather than the adult soldiers who recruited him.

Of course, this is speculation; how James viewed his future at that time, and how his physical and mental health was following his experiences will have depended on the support he was able to access, as well as the resources that were available to him.

2.3 Child labour

According to UNICEF (2017), an estimated 246 million children within the world's population are engaged in child labour. Furthermore, around one in four children aged 5–17 in the world's poorest countries are involved in child labour. Child labourers are deemed to be:

- children who are too young to work
- children who are engaged in dangerous or exploitative work that is detrimental to their health and wellbeing.

Such work includes:

Agriculture

Children may:

- be exposed to toxic pesticides or fertilisers
- use dangerous blades and tools
- carry very heavy goods.

Figure 7 Children carrying water

Mining

Children may have to:

- use poisonous chemicals
- face risks of mines collapsing
- work with explosives.

Construction

Children may:

- carry heavy loads
- work at heights without safety equipment
- risk injury from dangerous machinery.

Figure 8 Child labourer breaking stones

Manufacturing

Children may:

- use toxic solvents
- perform repetitive tasks in painful positions
- risk injury from sharp tools.

Domestic work

Children may:

- risk abuse
- work long hours
- often live in isolation away from their families and friends.

Children working in such conditions are essentially being deprived of their right to a 'playful childhood' because they are working. They are also more liable to encounter physical, social and psychological stresses that prevent them from interacting and socialising with peers.

Their education is affected because they are subject to disrupted schooling. Such disruption can then have serious consequences in terms of any future opportunity for safer or more financially rewarding employment. This can ultimately decrease their life chances and sense of self-fulfilment.

Low pay, high degrees of responsibility at a young age, lack of access to education as well as insufficient care and protection can all lead to heightened anxiety and lowering children's self-esteem and feelings of autonomy.

In the next section, you'll read a case study about Aamira, a refugee from Sudan which, although disturbing, really does stress the reality of some children's lives.

2.4 Refugee children

Refugee children are those who have been uprooted from their country through war, persecution or natural disasters. In doing so, they may have had to leave behind (possibly quite abruptly) some of the following:

- Family members who are unable or unwilling to leave, or who may have been tortured and/or killed (as encountered in some of the case studies during this session).
- Their childhood home and possessions, thus carrying with them only a small amount of luggage and personal goods in bags, rucksacks and suitcases.
- A sense of who they are – their previous identity and the meanings they had about life and connections may become very confused and dislocated.

How do you think you might feel if in just one day you lost all your close family, your home and possessions?

Loss, grief and bereavement are processes that have so far been under-researched as part of the refugee experience. Grief is very painful for most people and, although loved ones are missed and mixed feelings such as sadness and anger prevail, the intensity of such feelings might lessen over time. Furthermore, social support networks, spiritual beliefs and practices can all help the grieving process. Refugee children who are accompanied by surviving carers and siblings may also be more resilient in the face of the challenges and adversity they have faced, depending on the strength and security of the attachments they still retain.

Figure 9 The experience of being a refugee

Activity 4 Settling into a new setting as a young refugee child

Allow about 15 minutes

To illustrate the experience of a refugee child who has arrived in England, read the case study of Aamira. The case study is based on the experiences of one of the course authors working with a child who had similar experiences to Aamira. Then consider the following questions:

- How do you think Aamira's experiences have contributed to the difficulties she is having in settling into nursery?
- What are your thoughts about Aamira's experiences?

Case study: Aamira, a refugee child

Aamira is 4 and has recently arrived in England from Sudan. She is with her family: her parents and a brother and sister who are all seeking asylum. The family have been housed close to a children's centre and Aamira is to join the nursery for morning sessions. Aamira's key worker, Ellie, is very concerned about Aamira. Following a meeting with Aamira's mum, Ellie learns about some of the events that Aamira and her family have experienced since they had to leave their home.

Six months previously, rebel soldiers arrived in the village and Aamira's family ran into the bushes and hid. However, Aamira's big brother, Amani, who was 14, was taken by the rebel soldiers and after being beaten, he was burnt to death along with several other boys. Aamira and her family saw what happened to him. The family could not remain in the country because they would have suffered the same fate as Amani. Following a long and dangerous journey, the family spent three months in a refugee camp before they arrived in England.

Aamira is finding it difficult to settle into nursery. She is very still and rarely smiles. She is small for her age and tires easily; she picks at the unfamiliar food. She has not been heard to speak at nursery, although her mum says that she will speak in her native tongue occasionally at home. Ellie is trying to find out what play choices and activities will appeal to Aamira; she is longing to be able to support her and help Aamira to feel as if she belongs in the nursery.

Provide your answer...

Discussion

Aamira has experienced significant trauma in her young life; seeing her brother murdered, being forced to leave home and make a long and dangerous journey will all have taken a toll on her physical and mental health. The time in the refugee camp is likely to have been difficult for the whole family. They were grief-stricken and, with minimal resources, there was little that any of them could do to pass the time, which may have helped them to take their minds off their situation.

Aamina is expressing her response to her situation by exhibiting signs of depression and the effects of the trauma she has experienced. Most telling is her refusal to speak: her 'selective mutism' is a sign that she is experiencing considerable anxiety. Ellie knows that she will need lots of patience and gentleness to support Aamira; it will be important not to push her, especially in relation to her speech and communication. Finding play activities that Aamira likes will be potentially therapeutic for her; however, Ellie will have to observe her carefully and work with her mum to discover what these may be.

Children can experience post-traumatic stress disorder (PTSD) in much the same way as adults and can experience similar symptoms such as flashbacks, trouble sleeping, nightmares, reluctance to engage in activities they used to enjoy, as well as headaches or stomach aches. They may also repeatedly revisit traumatic events through play. However, the details of how young refugee children experience loss, grief and bereavement as a result of losing significant carers and then being forcibly removed from their homes is currently an under-researched area.

It is only more recently that research has focused on the experiences of unaccompanied minors, and how caring for each other through migration may have been key to the survival of these children. Think back to Session 3, where you learned about attachment processes and how they help to build a child's sense of worth and who they are in the world. You can perhaps see how, by caring for each other in adverse conditions experienced through migration, children may form significant attachments to each other (as with street children). Furthermore, the need to adapt to potentially hostile environments relatively quickly may even help child refugees to develop essential social skills such as empathy and emotional intelligence more rapidly, as well as greater individual and group resilience.

The following section looks at the experience of children who are separated from their families.

3 Separation from family

In many countries, it is generally accepted that children should be with their parents and family. However, this separation can be by choice, and that is fundamentally different to a forced separation. For example, in a range of countries, including families in the UK that send their children to boarding schools at a young age, long separations from their families are not always seen as problematic. Looking back to Irja's story in Session 1, it is evident that her ability to cope with being displaced and all the uncertainties that war brings was partly because she remained with her family.

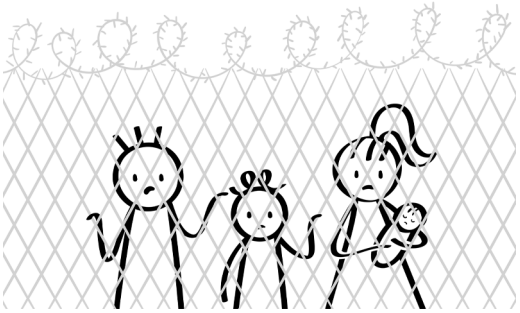


Figure 10 Children separated from their families

Many people continue to be displaced because of war or economic uncertainty. Large numbers of people from countries in Central and South America attempt to cross the border into the USA seeking a better life. However, US immigration policy is not currently working in a child-friendly way; in fact, the policy is violating children's rights. But it is not just the US that is 'managing' their 'border crises' in this manner. European countries are also managing this badly, and the Australian government frequently detains child refugees for prolonged prison-like conditions in smaller Pacific nations, in particular Nauru. There have been many news reports about children who are being separated from their parents, and in the next activity you will look at one.

Activity 5 Migrant children separated from their parents

Allow about 10 minutes

The following news item reports on how young children from Guatemala and El Salvador have been kept in cages and separated from their parents. Click the link below then scroll down to watch the second video: 'The sound of migrant children separated from parents'. Unsurprisingly, the content is very disturbing, and the video of the separated children is extremely upsetting.

You can find the video at the following link:
The sound of migrant children separated from parents

As you watch the video, think about the possible consequences of the children being separated from their parents.

Provide your answer...

Discussion

It is very likely that you found it difficult to watch the video and to realise that children are being treated in ways that are likely to affect their mental health. It is especially hard when we know so much about what contributes to good wellbeing in children and that the impacts of this mistreatment are likely to have a long-term impact. The emotional response of forced prolonged separation from their families can contribute to post-traumatic stress disorder. Unfortunately, around the world, young children are experiencing a range of different traumas that can have a huge impact on their mental health.

The content of this session has included some examples of different childhoods around the world and how the context of children's lives can impact on their mental health and wellbeing. There is a great deal of work being done around the world to help alleviate the factors that can negatively affect children. Some examples of such work are included in the 'Further reading' section at the end of the session.

4 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 6 Session 4 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do before the next session?

Provide your answer...

5 This session's quiz

Now it's time to complete the Session 4 badged quiz. It's similar to previous quizzes, but this time instead of answering five questions there will be fifteen.

Session 4 compulsory badge quiz

Remember, this quiz counts towards your badge. If you're not successful the first time, you can attempt the quiz again in 24 hours.

Open the quiz in a new tab or window then come back here when you've finished.

6 Summary of Session 4

In this session, you have looked at some of the factors that can influence children's health and wellbeing in different contexts around the world. Where children live in the world and their experiences can have a profound effect on their mental health and wellbeing.

You should now be able to:

- form an overview of the impact of a country's geography and politics on children's wellbeing
- explore social, economic and cultural influences on children's wellbeing and mental health
- appreciate some of the effects of migration on children's wellbeing and mental health
- re-examine the role of resilience in helping children cope with difficult, dangerous and traumatic circumstances.

You are now halfway through the course. The Open University would really appreciate your feedback and suggestions for future improvement in our optional end-of-course survey , which you will also have an opportunity to complete at the end of Session 8. Participation will be completely confidential and we will not pass on your details to others.

In the next session, you'll explore young children's mental health in education settings.

You can now go to Session 5.

Session 5: Wellbeing and mental health in education settings

Introduction

Around the world, many countries have developed national curricula for pre-school and school-aged children. Each curriculum includes principles aimed at improving children's emotional and social development. Implementing these aims means that practitioners and teachers have an increasingly important role in creating an environment that is conducive for children to develop good mental health and wellbeing.

In this session, you will explore some of the ways that educators in pre-school and primary school settings are approaching this responsibility. You will discover how the ethos of the early childhood and/or school setting is critical to children's wellbeing. For example, routines such as circle time (i.e. where the pupils and teacher come together in a physical circle to learn) that are embedded in practice can help adults to listen to children, and are important strategies for the development of good wellbeing and positive mental health.

Figure 1 Children playing together in a day care setting

In this session, you will explore how developing and implementing policies relating to anti-bullying and safeguarding can contribute to improving the mental health of children. Finally, you will consider the significance of play throughout a child's life in promoting good mental health and wellbeing.

Now listen to the audio introduction to this session.

Audio content is not available in this format.

Audio 1

By the end of this session, you will be able to:

- explore ways to promote positive wellbeing through the curriculum in early years education settings and primary schools
- be aware of the critical role of the key worker/person in early care and education settings
- consider the role of whole school approaches to promoting wellbeing in early years and in primary schools
- reflect on the role of policies in the prevention of mental health issues.

1 Promoting wellbeing in young children's care and education

As you have seen in previous sessions, there are many factors and resources within children's lives that can make a positive contribution to their mental health. Education and care settings can provide an ideal environment for children to develop a good sense of wellbeing. And for children who are experiencing negative factors in their lives and have fewer resources available to support them, a pre-school or school setting can be a place of refuge. Well-ordered daily routines that are aimed at addressing and meeting all children's needs, as well as policies and practice aimed at delivering high-quality care and education, play an important role in promoting positive wellbeing.

Figure 2 Playing outdoors

In much of this session, you will explore some of the strategies embedded within curricula for pre- and school-aged children that are aimed at supporting children's wellbeing.

In the next section, you will look at how such strategies are embedded in pre-school curricula.

2 Early years education and care curriculum

Many high-income countries have a curriculum specifically designed for the care and education of infants and pre-school children. In 1996, New Zealand was one of the first countries to create its curriculum for the education and care of very young children, known as 'Te Whāriki'. This is a Māori expression meaning 'the woven mat'. The New Zealand vision of Te Whāriki is outlined in the curriculum guidance as follows:

> Te Whāriki is underpinned by a vision for children who are competent and confident learners and communicators, healthy in mind, body and spirit, secure in their sense of belonging and in the knowledge that they make a valued contribution to society.
>
> (New Zealand Ministry of Education, 2017)

The Te Whāriki document goes on to emphasise the importance of developing good wellbeing in children by promoting their sense of belonging, providing routines and giving opportunities for communication. The four nations of the United Kingdom have each introduced their own early years curriculum:

> **England:** in 2007, the Early Years Foundation Stage was introduced, setting the standards for learning, development and care for children from birth to age five.
>
> **Northern Ireland:** in 2007, the Foundation Stage curriculum was introduced.
>
> **Scotland:** in 2006, Curriculum for Excellence was introduced.
>
> **Wales:** in 2010, the Foundation Phase was introduced.

The links to the current documents are listed in the 'Further reading' section at the end of the session.

In the same way that the New Zealand Te Whāriki curriculum includes principles that are aimed at developing good mental health, so do UK curricula. In the next section, you'll examine some of the aims of England's Early Years Foundation Stage.

2.1 Aims of the Early Years Foundation Stage

In England, the early years curriculum is the Early Years Foundation Stage (EYFS). The overarching principles for the EYFS are:

- every child is a unique child, who is constantly learning and can be resilient, capable, confident and self-assured
- children learn to be strong and independent through positive relationships
- children learn and develop well in enabling environments, in which their experiences respond to their individual needs and there is a strong partnership between practitioners and parents and/or carers
- children develop and learn in different ways.

(Department for Education, 2017a, p. 6)

The principle that each child develops and learns in different ways is important to bear in mind; however, the EYFS states that there are three characteristics of effective learning:

- **playing and exploring:** children being encouraged to 'have a go'
- **active learning:** children concentrate and keep on trying if they encounter difficulties, and enjoy achievements
- **creating and thinking critically:** children have and develop their own ideas, make links between ideas and develop strategies for doing things.

(Department for Education, 2017a, p. 10)

Figure 3 Children playing together and exploring

If learning is planned to give opportunities for children based on the characteristics of effective learning, they will be able to experiment with alternative ideas and find strategies for doing things, either on their own or working with others. The notion of 'having a go' is linked with being persistent and this in turn helps to develop resilience. The concept of children exploring and experimenting at their own pace helps them to develop concentration. Creating learning opportunities for children that include these approaches helps them to develop a sense of achievement, which is linked to wellbeing.

Children's wellbeing is therefore at the heart of the EYFS curriculum. In the next section, you will look at how positive relationships can help young children's wellbeing, focusing on the role of the key person. The term 'key person' is used in the EYFS: the aim of the role is similar to the role of 'key worker'.

The key person approach

The role of the key person is based on the work of Elfer, Goldschmied and Selleck (2003) and is a legal requirement of the EYFS statutory framework. The key person ensures that every child is designated a named member of staff who will 'help the child become familiar with the setting, offer a settled relationship for the child and build a relationship with their parents' (Department for Education, 2017a, p. 22, section 3.27).

Figure 4 Baby being handed over to his key person

The role of the key person is based on young children's need to have sound attachments with adults. Such attachments can form the basis of a positive relationship, which can help children to learn to be strong and independent.

The key person needs to respond sensitively to the child's feelings and behaviours. They need to reassure and support the child's emotional needs and wellbeing as they transition to a new setting or class. This person should be someone who the child sees as a familiar and friendly person, who is accessible and understands how the child is attempting to make sense of their environment and the expectations that they encounter. As a result, the child is likely to feel more settled, happy and able to explore spaces and engage in activities more independently.

Activity 1 The benefits of the key person approach

Allow about 10 minutes

What do you think are the benefits for a child in having a key person/worker? Make a note of your ideas.

Provide your answer...

Discussion

You may have included some of the following.

The key person/worker can:

- help their key child to develop positive and responsive relationships with staff and children
- help the child to have good quality interactions with other children and staff
- get to know the child very well

- create a welcoming environment for their key children and caregivers/parents
- know the key child's likes and dislikes
- plan appropriate activities that reflect the child's interests and help to promote development.

So, the role of the key person/worker is to get to know the child and their family or carers so that their needs can be met.

In the next section, you'll look at wellbeing principles within curricula for school-age children.

3 Primary school-aged children's mental health

In many countries, there has been increased understanding of the importance of promoting children's social and emotional development, which, as you have already seen, can improve wellbeing and promote good mental health. This has resulted in strategies aimed at supporting children's social and emotional development being embedded within school curricula.

Figure 5 Children in primary school

In England, children in primary education are aged 4–11 and the National Curriculum for primary education includes statutory guidance relating to Relationships Education, Relationships and Sex Education (RSE) and Health Education (Department for Education, 2019).

The guidance states that at the end of primary school, in relation to their mental wellbeing, pupils should know the following:

- that mental wellbeing is a normal part of daily life, in the same way as physical health
- that there is a normal range of emotions (e.g. happiness, sadness, anger, fear, surprise, nervousness) and scale of emotions that all humans experience in relation to different experiences and situations
- how to recognise and talk about their emotions, including having a varied vocabulary of words to use when talking about their own and others' feelings
- how to judge whether what they are feeling and how they are behaving is appropriate and proportionate
- the benefits of physical exercise, time outdoors, community participation, voluntary and service-based activity on mental wellbeing and happiness
- simple self-care techniques, including the importance of rest, time spent with friends and family and the benefits of hobbies and interests
- isolation and loneliness can affect children and that it is very important for children to discuss their feelings with an adult and seek support
- that bullying (including cyberbullying) has a negative and often lasting impact on mental wellbeing

- where and how to seek support (including recognising the triggers for seeking support), including whom in school they should speak to if they are worried about their own or someone else's mental wellbeing or ability to control their emotions (including issues arising online)
- it is common for people to experience mental ill health. For many people who do, the problems can be resolved if the right support is made available, especially if accessed early enough.

(Department for Education, 2019, p. 32)

Activity 2 Mental health and wellbeing in primary school-aged children

Allow about 20 minutes

Referring to the above extract about mental wellbeing from the Relationships Education, Relationships and Sex Education (RSE) and Health Education statutory guidance, consider the following questions:

1. What are your thoughts about the expectations of children's knowledge about mental wellbeing?
2. What skills and qualities do adults working with children in education settings need in order to support children to achieve these aims?
3. What can educators do to give children opportunities to gain this knowledge?

Provide your answer...

Discussion

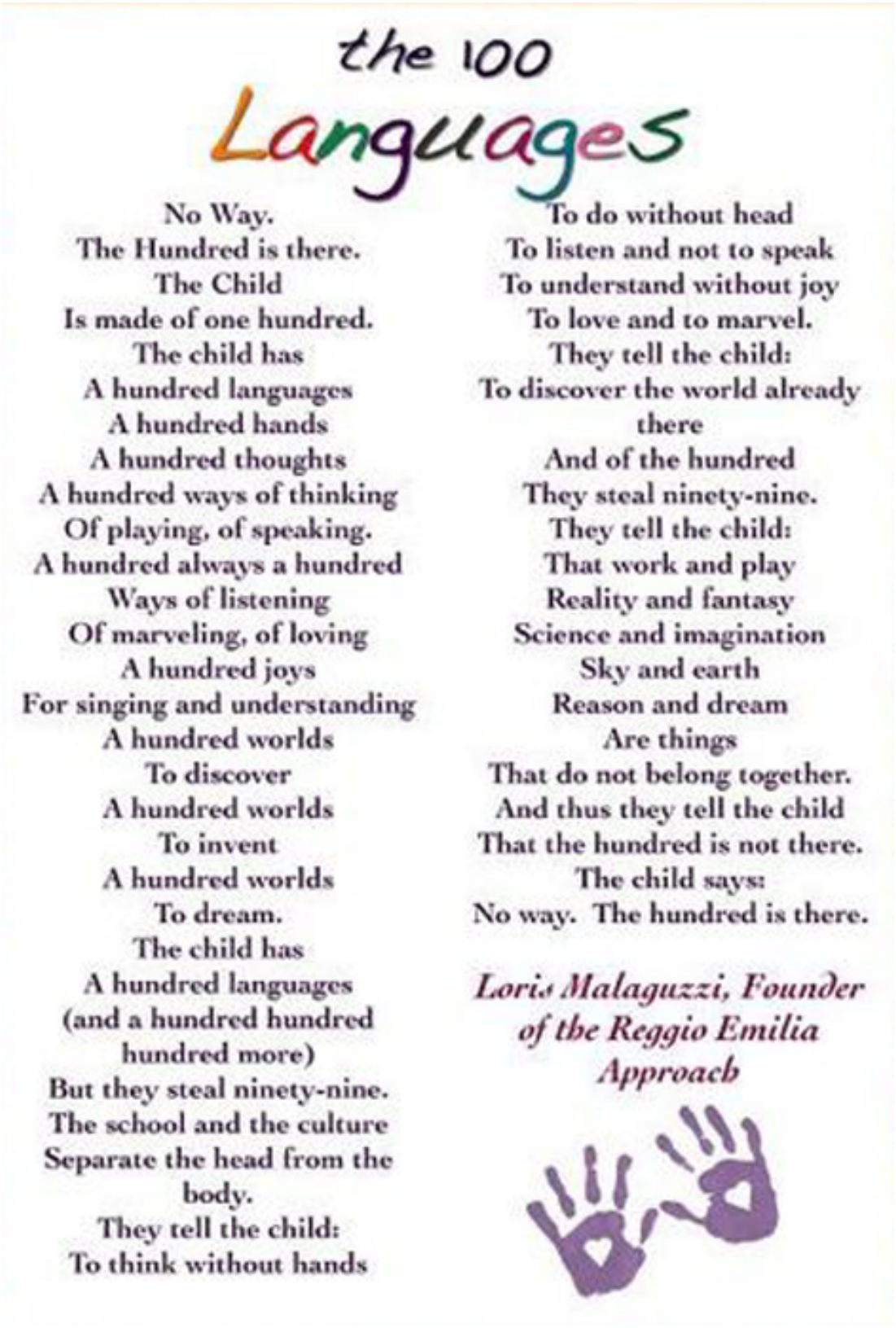
You may have thought that the topics relating to mental wellbeing that children are expected to learn between the ages of 4 and 11 are extensive. You may also have noted that some of the topics relate to what you've explored in previous sessions. Some of the topics will be discussed in later sessions; for example, Session 8 looks at the internet and cyberbullying.

The topics may also have made you think that educational settings play a significant role in promoting opportunities for children to engage in activities that make them feel positive about themselves, which of course links to wellbeing.

An important skill that educators need to develop in order to be responsive to children is that of listening. The following sections explore why this is important, and ways of creating opportunities to listen to children.

4 Listening to children

Listening to children is fundamental to understanding them; however, listening does not only mean hearing the words that children say. One of the pioneers of early education in Italy, Loris Malaguzzi (1920–94), was very attuned to the fact that children have many different ways in which they communicate their thoughts and feelings. He put together the following poem to express what he perceived as the 100 languages in which children attempt to express themselves if only adults could learn to listen attentively:



the 100
Languages

No Way.
The Hundred is there.
The Child
Is made of one hundred.
The child has
A hundred languages
A hundred hands
A hundred thoughts
A hundred ways of thinking
Of playing, of speaking.
A hundred always a hundred
Ways of listening
Of marveling, of loving
A hundred joys
For singing and understanding
A hundred worlds
To discover
A hundred worlds
To invent
A hundred worlds
To dream.
The child has
A hundred languages
(and a hundred hundred
hundred more)
But they steal ninety-nine.
The school and the culture
Separate the head from the
body.
They tell the child:
To think without hands
To do without head
To listen and not to speak
To understand without joy
To love and to marvel.
They tell the child:
To discover the world already
there
And of the hundred
They steal ninety-nine.
They tell the child:
That work and play
Reality and fantasy
Science and imagination
Sky and earth
Reason and dream
Are things
That do not belong together.
And thus they tell the child
That the hundred is not there.
The child says:
No way. The hundred is there.

Loris Malaguzzi, Founder of the Reggio Emilia Approach

Figure 6 The 100 languages of children
https://reggioemilia2015.weebly.com/the-100-languages.html

At this point, you might also note that the Chinese symbol for listening is as follows:

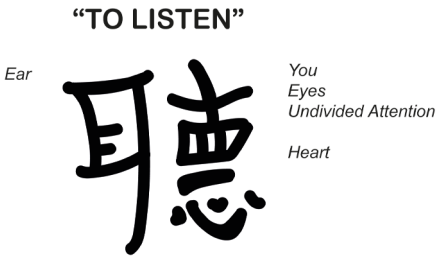


Figure 7 The Chinese symbol for listening

So, the verb ‘to listen’ moves beyond simple notions of ‘hearing’. Actions include using your eyes to observe; in this case, giving the child your undivided attention while you also open your heart and your mind to what the child is communicating to you.

Activity 3 Listening to children

Allow about 20 minutes

In the following video, practitioners talk about their involvement in a listening project in an early years setting. Watch the video then consider the questions that follow.

Practitioners in an early years setting

- What is the importance of listening to children?
- What can the process of listening involve when we go beyond simply using our ears to hear?
- How does the poem you read about the 100 languages link to aspects of listening to children that the staff in the video mention?
- How do issues in the video relate to any previous work you have done in this course?

Provide your answer...

Discussion

You may recall staff talking about how they have found themselves increasingly open to all the different ways that children express themselves, and that listening goes beyond simply hearing what the young child says. Listening is as much about close and attentive observation, waiting patiently and the imitation of physical gestures, but wherever possible with the child leading the process.

You probably took note of two important processes that you have previously considered: attachment and attunement, which were in Session 3. You will come across these processes again when you examine the role of the counsellor in Session 7. Communication with the child and being finely attuned to everything they do helps to form effective social and emotional attachments.

The key component of listening to the whole child is for the process to be child-led. By observing and listening, adults can build up a much richer picture of the child and how they experience the world in which they live. In the broadest sense, listening can help to promote good wellbeing.

In the next section, you will explore one example of a practical way that adults in educational settings can listen to children.

4.1 Practical ways of listening to children: circle time

Creating opportunities to listen to children is an important way of developing confidence. One example of such an opportunity is circle time.

Circle time can be used in pre-school or primary school settings and is an approach that can help children to have their voice heard in a group. Doing so can help to develop and boost children's self-esteem.

Figure 8 Circle time

Circle time can help to foster positive and effective social relationships between children. At its heart is the time set aside to enable adults and children to join in activities that help to promote a sense of belonging within a safe emotional space where feelings can be explored and experiences shared. Circle time can help to improve children's social and emotional skills.

In the next section, you will look at the importance of play and creativity in promoting children's wellbeing.

5 The importance of play and creativity in promoting children's wellbeing

In Session 4, you considered the importance of children's rights. One of those rights is the right to play.

Article 31 of the United Nations Convention on the Rights of the Child (UNCRC) states that all children (from birth) have the right to 'rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts' (UNICEF, 1989, p. 10).

The right for children to be able to play has influenced many of the early years curricula that you have looked at earlier in this session.

While early years curricula focus on play as a vehicle for children's learning, the importance of play and creativity in primary education is sometimes not regarded as being as important. However, it is essential that all children have opportunities to engage with different types of play and that they have creative opportunities.

Figure 9 Play in primary schools

6 Promoting good mental health in primary education

As you saw in Session 3, the old saying that ‘prevention is better than cure’ is especially relevant to developing wellbeing and preventing mental health problems. In primary education, there are many initiatives aimed at promoting wellbeing. In the next section, you will explore how taking a whole school approach is important to achieve this aim.

6.1 A whole school approach

Glazzard and Bostwick (2018) outline how schools can address mental health through the curriculum as a way of reducing stigma and increasing pupils’ knowledge about topics including anxiety, depression, self-harm and resilience. As well as increasing knowledge, an aim of the whole school approach is to help children to develop strategies that help them to reduce the impact of factors or feelings that may impact negatively on their mental health. In addition, children are encouraged to be aware of and sensitive to other peers who may be experiencing such difficulties.

The curriculum of a school that is taking a whole school approach to promoting positive mental health includes opportunities for children to engage in play, physical activities, art, music, dance and drama. It is also important to include opportunities for discussions about gender and identity, race and ethnicity, religion and belief systems as well as disabilities and their impact, which can inform children about difference. By doing so, children who feel ‘different’, perhaps because of a disability for example, may feel a greater sense of belonging.

Developing effective policies that are aimed at addressing children’s wellbeing and mental health is a way that schools can work together and take a whole school approach. Policies relating to children’s wellbeing and mental health are discussed in the next section.

7 Policies to improve children's mental health and wellbeing

You'll now move on to how national government and local policies in educational settings can support children's health and wellbeing.

7.1 Government policy

In addition to curriculum policy, since 2010, successive UK governments have pledged to improve support for children's mental health. Here are some of the main policies.

The following is a summary of key policies in England taken from a House of Commons Briefing Paper,
Children and young people's mental health – policy, services, funding and education (Parkin, Long and Gheera, 2020).

- The **Future in Mind taskforce report** (Department of Health and Social Care, 2015) set out ambitions to improve mental health.
- The **Five Year Forward View for Mental Health** (NHS Mental Health Task-force, 2016) includes specific objectives to improve treatment for children and young people by 2020/21.
- The **Transforming Children and Young People's Mental Health Provision Green Paper** (Department of Health and Department for Education, 2017), which was published jointly by the Department of Health and the Department for Education. Two of the main aims will require schools to designate a senior lead to oversee the approach to mental health and wellbeing, and to fund mental health support teams that are supervised by NHS staff that will be linked to schools.
- The **NHS Long Term Plan** (NHS, 2019) restated the Government's commitment to deliver the recommendations in the Five Year Forward View for Mental Health and set out further measures to improve the provision of, and access to, mental health services for children and young people.
- The **Relationships Education, Relationships and Sex Education (RSE) and Health Education** (Department for Education, 2019) guidance is part of the National Curriculum in England and has been discussed in Section 2 of this session.

Government policies at national level are aimed at providing guidance about the services that are required to respond to the mental health needs of young children. However, policies at local level in education settings can also make a positive contribution to improving children's mental health.

7.2 Policies in settings

Early years and school settings have many policies that cover a wide range of issues. Policies that relate to health and wellbeing are likely to address mental health. However, there are other policies that may not appear to be directly linked to wellbeing.

Figure 10 Policies and procedures

Activity 4 Policies that help to support children's mental health

Allow about 10 minutes

1. List the policies in an education setting that you think can help to support children's mental health.
2. Give a brief explanation of why and how the policy can help to support children's mental health.

Provide your answer...

Discussion

You may have thought of the following:

- behaviour management
- safeguarding
- anti-bullying interventions.

The following sections explain the ways that these policies can help to support children's mental health.

Behaviour management

Children's emotions are linked to their wellbeing and mental health. In a pre-school or school setting, there are many triggers for children to become highly emotional; for example, other children taking their toys, being asked to stop an enjoyable activity or simply being tired or hungry. As you saw in Session 2, understanding children's development can help adults to appreciate that children's reactions can vary depending on their age and stage of development. Knowing the circumstances of the child and their family can also help adults to understand the reasons why children behave in the way they do.

Figure 11 Managing behaviour in primary schools

Young children need a calm and consistent response from the adults around them. For this reason, education settings will have a behaviour policy written by staff in the setting.

Ideally, policies should be written with input from all staff because this helps to develop a shared understanding of the behavioural issues (and expectations) that are relevant to the children in that specific setting. More recent initiatives regarding creation of policy and putting such policy into practice highlight the need to actively involve children in such decision-making from an early age so that, as rights holders, they can have a genuine say in the expectations, rules, routines and practices that affect their daily lives. Involving young children in a more active role as part of democratic decision-making processes can also help them understand what active citizenship entails. Including all stakeholders in writing policies is an example of a whole school approach.

Safeguarding

Safeguarding children and preventing abuse is important for many reasons, including that childhood abuse can lead to poor mental health.

Figure 12 Safeguarding children to recognise and stop abuse

Therefore, by being aware of the safeguarding policies in their setting and implementing them effectively, all adults who work with children can contribute to the prevention of mental health issues not only in childhood, but across the age span.

Anti-bullying

Many schools' bullying policies are aimed at responding to bullying once it has started. However, preventing and tackling bullying is an effective way of improving children's mental health and wellbeing (Brown, 2019).

Figure 13 Playground bullying

Examples of anti-bullying strategies that can be part of a school's policy include the use of circle time, peer group councils and buddy schemes for pupils who are at risk of being bullied. Whole school approaches can include anti-bullying assemblies and a week dedicated to activities linked to anti-bullying.

For more information about the government's guidance for schools, see 'Preventing and Tackling Bullying' (Department for Education, 2017b).

On page 8 of the guidance, bullying is defined as follows:

> Bullying is behaviour by an individual or group, repeated over time, that intentionally hurts another individual or group either physically or emotionally. Bullying can take many forms (for instance, cyber-bullying via text messages, social media or gaming, which can include the use of images and video) and is often motivated by prejudice against particular groups, for example on grounds of race, religion, gender, sexual orientation, special educational needs or disabilities, or because a child is adopted, in care or has caring responsibilities. It might be motivated by actual differences between children, or perceived differences. Stopping violence and ensuring immediate physical safety is obviously a school's priority but emotional bullying can be more damaging than physical.
>
> (Department for Education, 2017b, p. 8)

You have seen how policies that do not appear to be directly linked to supporting children's wellbeing and improving their mental health can be instrumental in doing so. You may also have thought of other policies that could help to support children's wellbeing.

By adopting a whole school approach where there is a supportive ethos and an environment where children can flourish, much can be done to prevent mental health problems from developing. However, some children will inevitably require further interventions, as you will see in the following section.

8 Early interventions: going beyond preventative

Much of what you have explored so far has highlighted the importance of creating an environment for children that is conducive to good wellbeing. However, there will be times when children are adversely affected by what is happening in their lives and require additional support. By offering an early intervention, it is possible to reduce the impact of events on children's mental health. Examples of interventions that are aimed at improving children's wellbeing include mindfulness and relaxation activities. In many schools, nurture groups are also used. In the next section, you will focus on the role of nurture groups in primary schools.

8.1 Nurture groups in primary schools

Nurture groups are increasingly being used to offer short-term support to children who are experiencing social and emotional difficulties. Nurture groups are described as:

> The classic model for Nurture Groups involve classes of about 10–12 children, typically in the first few years of primary school, and staffed by a teacher and teaching/classroom assistant. The aim of the Groups is to provide children with a carefully planned, safe environment in which to build an attachment relationship with a consistent and reliable adult.
>
> (Sloan et al., 2016, p. 4)

In Northern Ireland, the Department of Education funds nurture groups, and in the evaluation of nurture groups carried out by Queen's University, they state:

> This evaluation found clear evidence that Nurture Group provision in Northern Ireland is highly successful in its primary aim of achieving improvements in the social, emotional and behavioural skills of children from deprived areas exhibiting significant difficulties.
>
> (Sloan et al., 2016, p. 4)

Part of the aim of nurture groups and other early intervention approaches is to give children opportunities to develop resilience, but what is this and why is it so important for good mental health?

8.2 Developing resilience

As you saw in Session 2, resilience is the ability to recover, or bounce back from adverse experiences. This means that we have a go at doing something and if we don't succeed the first time, we try to achieve the same goal, but perhaps approach it in a different way.

Children can develop emotional resilience following exposure to risky or stressful events; however, their ability to 'bounce back' is increased with support from those around them. So, if children develop resilience when faced with exposure to risk and stress, it follows

that if they are protected from all such events (i.e. they are ‘wrapped in cotton wool’), they may not have opportunities to develop emotional resilience.

However, it is not only emotional events that can help to build resilience. Giving children opportunities to take part in risky play helps to build resilience because they learn to assess risks.

Figure 14 Child on climbing frame

9 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 5 Session 5 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do before the next session?

Provide your answer...

10 This session's quiz

Well done – you have reached the end of Session 5. You can now check what you've learned this session by taking the end-of-session quiz.

Session 5 practice quiz

Open the quiz in a new window or tab then come here when you've finished.

11 Summary of Session 5

In this session, you've focused on how pre-school and school curricula can support young children's wellbeing and mental health.

You should now be able to:

- explore ways to promote positive wellbeing through the curriculum in early years education settings and primary schools
- be aware of the critical role of the key worker/person in early care and education settings
- consider the role of whole school approaches to promoting wellbeing in early years and in primary schools
- reflect on the role of policies in the prevention of mental health issues.

In the next session, you will explore how professionals in health, education and social sectors can work together to support children's health and mental wellbeing.

You can now go to Session 6.

Session 6: Professional support for children and their mental health

Introduction

During the previous sessions, you have seen that there are many systems around the child and their family that can support a child's mental health. Within the wider community, therapy and support can be in the form of community or clinic-based as well as hospital (including inpatient) health services. Other valuable support can be via social care or education professionals working for schools, local authorities and charities. Working together with several different professionals and agencies can yield benefits in terms of a child's mental health, but also some challenges, and you will consider these points.

In this session, you will explore some of the key principles of working with professionals or agencies and discover why multidisciplinary working is important to help support and improve children's mental health.

Now listen to the audio introduction to this session.

Audio content is not available in this format.
Audio 1

By the end of this session, you will be able to:

- understand some of the roles of key health, education and social care professionals who support children's mental health and wellbeing within the community
- have knowledge of referral processes to services such as Child and Adolescent Mental Health Services (CAMHS)
- explain many of the principles, benefits and challenges of working with other professionals as part of an interdisciplinary approach to children's mental health
- reflect on the ways in which voluntary organisations such as Home-Start and other statutory services can work together to support the wellbeing of young children and their families.

1 Professionals involved in children's mental health

There are many health and social care professionals who work to support, treat and ultimately to improve the mental health of children.

Here are examples of professionals who may work with children, and their roles and responsibilities.

Educational psychologists: have studied psychology and have taken additional training and study to specialise in working with children and families in education settings. Psychologists are not medical doctors (which include psychiatrists) and therefore do not prescribe medication. They can assess children and recommend interventions to support children experiencing social and emotional difficulties.

Activity 1 The role of an educational psychologist

Allow about 30 minutes

Watch the following interview with Liz talking about her work as an educational psychologist (about 5 minutes). Then reflect on each of the questions that follow and make a note of your responses. Watch the clip a few times if that helps you recall what was said.

Video content is not available in this format.

Video 1

Part 1

What kinds of work do educational psychologists do?

Provide your answer...

Discussion

Liz described a range of different tasks and how these might also depend on the expertise and interests of the individual psychologist. Visiting schools and talking with staff, children and parents were mentioned, as was training.

Liz talked about managing assessments of pre-school children herself, as well as having responsibility for children with specific learning difficulties (such as dyslexia) and those with social and emotional issues.

Part 2

What other people and professionals might educational psychologists work with?

Provide your answer...

Discussion

Liz talked about working in a team with other colleagues and also how important it was to liaise with mental health teams, social workers and systems that surround the individual child. You may recall that these systems have been mentioned throughout the course.

Part 3

What is important to consider when assessing individual children?

Provide your answer...

Discussion

Liz explained how the 'whole child' needs to be seen as part of systems that includes the family and the school that the child is interacting with daily. The child is the central focus, but should never be perceived as an isolated individual.

Part 4

What does Liz suggest is one of the most important skills to have?

Provide your answer...

Discussion

Throughout the course, but particularly in Session 5, you've considered the importance of listening to the child. Here, Liz emphasises the need for the same skill but with a wider application, stressing the need to listen attentively to all those involved with the child – including the child themselves of course – in order to find out how each person perceives the situation. Such listening can be very intense and tiring, especially when this involves hearing about adverse childhood experiences first-hand on a day-to-day basis, which is also why Liz highlights the need for professionals to take care of their own health and wellbeing to avoid 'burnout'.

Part 5

Why does Liz suggest that the role is not being a 'problem solver'?

Provide your answer...

Discussion

Liz brought in an interesting metaphor of the work being similar to a detective gathering evidence from everyone so that a bigger picture of the child and the problem or situation can be 'drawn up'. In this way, ideas can be thought through with others, including the child themselves, and the problem might even be reframed or perceived in a different light.

Health visitor: a registered general nurse who has done additional training to become a registered health visitor. Their role is primarily public health orientated and specifically focuses on working with children aged 0–5 years and their families.

Psychiatrists: medical doctors who have taken further training to study the speciality of psychiatry. Child and adolescent psychiatrists have specialised further and work with children with mental health conditions in both the community and inpatient mental health units. Psychiatrists can diagnose mental health conditions, prescribe medication, provide psychotherapy (i.e. talk-based therapies) and make recommendations for other interventions. They usually work in NHS-funded multidisciplinary teams with other professionals, including mental health nurses.

School nurse: a registered nurse who has done additional postgraduate training to become a specialist in children's physical and mental health.

Figure 1 A school nurse

Social workers: support children and their families, helping to protect children's rights and safeguarding children. They build relationships between agencies and help advocate for the child and ensure they receive the formal supports and resources that they are entitled to.

Special educational needs coordinators: often referred to as SENCOs. This role is statutory as part of the Special Education Needs and Disability (Department for Education and Department for Health and Social Care, 2014) legislation, which requires education settings to have a designated teacher who coordinates the special educational needs of children.

Activity 2 The role of the SENCO

Allow about 30 minutes

Watch the following clips from an interview with Christine about her role as a special educational needs coordinator. You can either watch the clips all together or one at a time at your own pace.

Part 1

As you watch the first clip, make some notes in response to the following:

- how Christine explains what is meant by the role being 'mandatory'
- what the routes for referral and identification of special needs tended to be
- how social and emotional difficulties tended to be seen by staff.

Video content is not available in this format.
Video 2

Provide your answer...

Part 2

As you watch the second clip, reflect on the following question:

- How did Christine attempt to look behind the presenting behaviour of the child?

Video content is not available in this format.
Video 3

Provide your answer...

Discussion

You may have noticed how Christine attempts to think about the behaviour from the child's perspective and what they might be attempting to express. As you have seen in

previous sessions, all behaviour is a form of communication, which is understandable as very young children do not always have the ability to express themselves clearly using words alone. It is the responsibility of adults to find out as sensitively as possible how children are understanding the world around them and the relationships they experience.

Part 3

In the third clip Christine discusses how the school attempted to access wider support services. Reflect on the following:

- What kinds of support were available?
- What were the challenges at the time of accessing external mental health support?

Video content is not available in this format.
Video 4

Provide your answer...

Discussion

At the time that Christine was SENCO, the school was unable to make direct links to mental health services and had to make referrals through over-stretched GP practices. As you may recall from Session 5, there is an increasing demand for effective and joined-up thinking due to recent government initiatives for more coordinated mental health support teams.

Part 4

The fourth clip highlights the important relationships Christine built up with parents in a very sensitive way. Note how she describes parents as 'our allies' in school.

Reflect on the story Christine narrates of one child, and the role of curiosity and listening to parents and the child that helped the communication process evolve in such a positive way.

Video content is not available in this format.
Video 5

Provide your answer...

Part 5

As Christine reflects on her role in the last clip, notice how she stresses the conflicts that inevitably arise within the role, but also how keeping the child's welfare as central and helping the child to have a 'voice' that can be heard by others can ultimately make a difference.

Video content is not available in this format.
Video 6

Provide your answer...

Teaching assistants: perform many important roles within schools, either working alongside the class teacher with targeted children who have special needs, or with small groups of children to help boost maths and literacy skills in particular. In more recent years their role has expanded, and some teaching assistants with higher-level formal qualifications have received further training to help them to nurture the wellbeing of children throughout the school.

Figure 2 A Teaching assistant supporting a child

Mental health nurses: Some mental health nurses have received further training and work in Child and Adolescent Mental Health Services (CAMHS) either in the community or in inpatient units, making them experts in supporting children with mental health conditions. Other health and social care professionals also specialise in child and adolescent health and work in CAMHS too, including social workers, practitioner psychologists (including clinical psychologists), child psychotherapists (specialists in talk-based therapies) and occupational therapists.

Therapist: A range of specialists who are skilled in a particular therapy or field, which can include the disciplines of speech and language therapy, psychotherapy, family therapy (where a therapist works together with the family unit in systemic therapy) and occupational therapists. All can make a valuable contribution to children and their mental health.

2 Getting help from other professionals: making referrals

Some children will develop a mental health condition that is more severe or complex and requires support that goes beyond the skills, knowledge and professional boundaries of those who are already working with the child within their pre-school or school. When this situation arises, a professional may decide that a child is likely to need to access specialist assessment and subsequent interventions such as medication or talk-based therapies.

In Session 1, you learned about the work of CAMHS. These are multidisciplinary teams made up of health and social care professionals who have received additional 'on-the-job' training, with many also having postgraduate qualifications in relation to providing comprehensive mental health assessment, treatment and support to children and their families. In order to access CAMHS, a professional – usually a general practitioner, sometimes a school nurse or teacher – can make a referral to a child's local CAMHS.

Figure 3 A child having therapy

CAMHS are organised differently around the UK and delivered by the National Health Service. Details of how they are organised in your local area can be found online. As a professional referring a child to CAMHS, or another agency, it is important to involve the parents and gain their consent, so that they are fully aware that a referral is being made. It is also important to provide as many relevant details as possible in the referral letter, using language that is clear and non-judgemental. Involving parents will also help to gather important details and information that will help ensure an accurate referral is made to CAMHS. Given that CAMHS in the UK receive many referrals a year, and that they have limited capacity, some children that are referred are not seen in CAMHS. However, the child's local CAMHS should be able to identify other forms of support that can be accessed to assist the child and/or their family.

3 Interdisciplinary working

When professionals from different specialisms or disciplines work together to support children and their mental health, this is often described as ‘interdisciplinary working’.

3.1 Key principles of interdisciplinary and multi-agency working

Earlier in this session, you learned about some of the professionals who can be involved in providing treatment and support to children with mental health conditions. When several different professionals work together, this is described as interdisciplinary (or sometimes multidisciplinary) working, meaning that the professionals come from different disciplines to form a team of people who support the child and their family.

It is common for a team who work together to refer cases to other agencies; for instance, it may be appropriate to refer a child to a voluntary organisation for further support, as will be discussed in Activity 4. Other agencies may include education settings. Therefore, the combination of different disciplines of health professionals and representatives from other agencies, such as education settings, can be described as multi-agency working.

3.2 Benefits of interdisciplinary and multi-agency working

There are many benefits to having different disciplines of professionals who are specialists in children’s mental health.

Each discipline will have skills and knowledge about how their discipline can help improve the mental health of the children they are working with. For example:

- A psychiatrist will know if medication is appropriate (for most childhood conditions medication is only reserved for a selected number of conditions that are severe and enduring) and is applicable to prescribe.
- An educational psychologist will have the skills and knowledge to be able to assess children’s behaviour and will be able to work with educators and parents to implement a plan (often referred to as an Individual Education Plan/IEP) that helps them to understand and manage their behaviour.

When another agency is involved, this can bring in further skills and knowledge.

Educators – for example, a practitioner in an early childhood setting – are likely to know a child very well because they spend a lot of time together. Practitioners work with children in an environment that is familiar to them; they will be able to give a different perspective about the child’s behaviour. They are likely to know the parents or carers and are likely to have knowledge of the family, and possibly a positive working relationship with them, all of which may be useful in planning the treatment of the child’s mental health.

3.3 Challenges of interdisciplinary and multi-agency working

There can be challenges in a group of different professionals all coming together. There may be up to 10 different disciplines and agencies working with a child and family; therefore it is not surprising that each professional may have different priorities and perspectives, and sometimes these can be conflicting. For example, CAMHS may be discharging a child with no further follow-up, and other professionals may think the discharge is premature.

Communication can be a key issue when different disciplines come together to work with a child and family. It is important that all professionals have an overview of the child's mental health, but gaining the big picture can be difficult for a range of reasons. Professionals can end up feeling as if they are holding an individual piece of a jigsaw, and may not be able to come together with other professionals to see how their piece of the jigsaw contributes to the big picture. This approach is often referred to as working in a silo, meaning that there is a lack of information sharing and collaboration.

Figure 4 Professionals with their individual piece of the jigsaw

There are often good reasons why communication can be a barrier to effective interdisciplinary working. These reasons include:

- Confidentiality: there may be concerns about what is confidential information. However, confidentiality is often interpreted as not passing on any information. In reality, confidentiality means that information should be shared on a 'need to know' basis with relevant colleagues. Professional codes of conduct are often bound by a need for confidentiality and this too can make professionals cautious about passing on information.
- Location: the different professionals involved may work for different employers, are likely to work in different locations and have different line management.
- Staff availability can be a barrier to effective communication. Staff may be unavailable (e.g. when a teacher is in class during most of the working day) or on leave.

3.4 Interdisciplinary and multi-agency working: ingredients for success

Different professionals, or disciplines, working together is an effective way of ensuring that children with mental health problems and their families get the best support possible. However, there are some ingredients that can make working together very successful.

Activity 3 The ingredients that make up successful interdisciplinary approaches

Allow about 10 minutes

In the previous sections, you have explored the barriers to and challenges of interdisciplinary working. Now make a list of what you think are the ingredients for success when several professionals from different disciplines in different locations are working with a child and the family to support the child's mental health.

Provide your answer...

Discussion

You may have included some of the following on your list:

- Good communication: for example, by attending meetings and being prepared to be able to make a 'positive contribution', responding to requests for information.
- Knowledge and understanding of others' roles, being aware that different professionals may have different priorities and constraints.
- Commitment from all to be united in achieving the best outcomes for the child and the treatment and management of their mental health.
- Proactive approach with a focus on identifying solutions, some of which may require some creative thinking, that will help to remove or reduce barriers.

4 Working with voluntary organisations

Voluntary organisations can play a significant role in supporting children's mental health by working with families. In a similar way to children, parents can struggle with events in their lives that can make it difficult for them to cope with parenting their children.

Figure 5 Times when parents need support

Events such as the death of a family member or friend and the associated grief linked to the bereavement can understandably have a negative impact on parents (and children) and their mental health. There are several voluntary organisations that offer advice and support for families in times of difficulty, including after a bereavement; for example, CRUSE supports bereaved families. Home-Start UK offers more general support to children and families who are experiencing difficulties for a range of reasons.

Some of Home-Start's work is focused on supporting mothers who are experiencing post-natal depression. Mothers with post-natal depression are more likely to have difficulty forming an early attachment with their baby, and this in turn can impact on their children's mental health.

Activity 4 Family support through Home-Start

Allow about 20 minutes

Read the following case study by a colleague at The Open University who is also a volunteer for Home-Start. The case study is about Kasia and Janek and their children. Then consider your responses to the questions that follow.

Case study: Kasia and Janek

Kasia and her husband Janek live in a flat in a rural village in the south of England, where they have been for almost a year with their children, Lena, aged two-and-a-half years, and a baby boy, Leon, aged three months.

The couple have a car and Janek drives to work each day, but Kasia does not drive. They did not have any friends or family locally, having moved from London. Kasia had become isolated and was feeling anxious and depressed, finding it difficult to leave the first floor flat with two young children. She often felt tearful. Consequently, the children spent very little time outside the flat or in the company of different people.

Kasia's health visitor referred the family to Home-Start as she was concerned about Kasia's wellbeing and that of the two children. Lena was beginning to speak in Polish

but had only a few words. Some of her physical skills appeared slow to develop. She didn't run or jump or attempt to kick a ball. Indeed, it was difficult to allow or encourage such activities without disturbing the people in the flat below, who worked nights. Kasia told her Home-Start volunteer that she would like help in getting out and about and making new friends.

Over a nine-month visiting period, the Home-Start volunteer and the family started by walking to the local shop and duck pond together, encouraging Lena to help look for items on the shelves, chat to the shop assistant and hand over money to pay. Lena fed the ducks and chatted about them, Leon watching eagerly with waving hands.

They progressed to finding out about a parent and toddler group in the local church, which they attended together weekly. The Home-Start volunteer helped broker communication between Kasia and other local mothers while helping the children to take part in the play activities, including a toddler slide and climbing frame. Every session ended with nursery rhymes and singing, which Kasia and the Home-Start volunteer repeated with the children once they had arrived back at the flat.

By the end of the nine months, Kasia had made two new friends with children locally. They helped her to use the local bus service for outings with the children and to visit a preschool, where Lena started when she was three.

Questions for reflection:

- In what ways did the Home-Start volunteer help to support Kasia's health and wellbeing?
- In what ways did the Home-Start volunteer's help contribute to the children's health and wellbeing?
- What skills did the Home-Start volunteer use to help the family?
- What local resources helped the family's health and wellbeing?

Provide your answer...

Discussion

You may have thought that the Home-Start volunteer helped Kasia to develop confidence simply by helping her to leave the flat. Clearly, Kasia was worried about disturbing the neighbours below, who may have become annoyed with the family. This may have led to her limiting the children's movement in the flat, which meant that they were not given the opportunity to develop their physical skills. Getting out of the flat helped Kasia to meet new people and to interact within her local community.

The Home-Start volunteer showed that she had patience and she didn't rush Kasia. She had carefully worked out a step-by-step approach to supporting Kasia, starting with walks to the shop and the duck pond and ending by making new friends. During the nine months, she supported Kasia to make friends by initiating conversations with other mothers and then drawing Kasia in to the chats. As Kasia's first language isn't English, she may have helped Kasia's confidence by interpreting some words or explaining parts of the conversation.

The local resources helped the whole family. The health visitor is an employee of the National Health Service, but part of their role is to offer support to young children from birth to five years of age. By recognising that the family could benefit from support and

being aware that Home-Start was available in the local area, she was able to make a referral. The neighbourhood had the duck pond, which was a draw for the children and a gentle introduction to the area for Kasia. The local shop also gave Kasia the opportunity to socialise and learn more about living in England.

Figure 6 Feeding the ducks

Fortunately, the family were comfortable going to a group based in a local church (some families would not be willing to attend sessions conducted in a place of worship) as the church offered a parent and toddler group, giving parents the opportunity to come together and socialise. And very importantly, the parent and toddler group was well-resourced with suitable play equipment and toys, which gave the children the opportunity to develop their physical skills: an opportunity that was not available at home.

The songs and rhymes that Kasia and the children learned gave them an opportunity to do an enjoyable activity together, thus helping them to bond. The rhymes also helped the family to develop their English and for the children to develop their communication and language skills.

As well as illustrating the work of a voluntary service, the case study highlights how, because the health visitor was aware of the benefits of a voluntary agency, she was able to draw on the services of the Home-Start volunteer to support the whole family to improve their wellbeing.

5 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 5 Session 6 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do before the next session?

Provide your answer...

6 This session's quiz

Well done – you have reached the end of Session 6. You can now check what you've learned this session by taking the end-of-session quiz.

Session 6 practice quiz

Open the quiz in a new tab or window and come back here when you have finished.

7 Summary of Session 6

During this session, you have explored some of the benefits of a range of different professionals working together to support children who are experiencing mental health difficulties and their families. You have considered the importance of working in effective ways with other professionals. You have also thought about the importance of voluntary organisations who can support children and families to improve their wellbeing and mental health, illustrated by the case study of Home-Start.

You should now be able to:

- understand some of the roles of key health, education and social care professionals who support children's mental health and wellbeing within the community
- have knowledge of referral processes to services such as Child and Adolescent Mental Health Services (CAMHS)
- explain many of the principles, benefits and challenges of working with other professionals as part of an interdisciplinary approach to children's mental health
- reflect on the ways in which voluntary organisations such as Home-Start and other statutory services can work together to support the wellbeing of young children and their families.

In the next session, you will look at the effects of play therapy and the role of the trained counsellor in supporting children's mental health and wellbeing. You will be introduced to activities to which children seem to respond well. You will also have the opportunity to reflect on the carefully guided use of prescribed medication for children to treat a small number of mental health conditions, and how more trauma-informed schools and organisations are emerging.

You can now go to Session 7.

Session 7: Exploring some of the interventions to support children's mental health

Introduction

In the last session, you looked at some of the roles of different professionals and the processes that relate to facilitating children's mental health and wellbeing within the child's community. This session, you will be looking in more depth at several of the other therapeutic approaches that might be used by practitioners such as therapists and counsellors. You will also watch a video demonstrating how engaging playful activities are used with younger children and how these can be adapted as forms of therapeutic occupation or activities.

You will be introduced to the ways that specially trained dogs are used therapeutically in non-clinical settings and what the positive advantages of this creative approach might be. You will also have the opportunity to reflect on the use of medication to treat some mental health conditions, in particular attention deficit hyperactivity disorder (ADHD). In addition to this, you will explore behaviour management through the use of a particular toolkit and re-examine the role of schools, parents and wider organisations in helping to support children's mental health and wellbeing.

Now listen to the audio introduction to this session.

Audio content is not available in this format.
Audio 1

By the end of this session, you will be able to:

- recognise how the power imbalances between child and adult can affect the therapeutic processes
- understand what is meant by cognitive behavioural therapy (CBT)
- appreciate the role of play and creativity in counselling and therapy with young children
- realise some of the challenges associated with prescribing medication to treat a child's mental health condition
- understand how parents might be helped to manage children's behaviour and support their wellbeing.

1 Counselling and therapy

One of the issues to be aware of around counselling and all other talk-based therapy is how terms are used by a range of professionals across numerous different contexts. For example, teachers and support workers in schools and in the social care services may well use counselling micro skills very effectively (e.g. active listening and paraphrasing). However, they will not be trained counsellors or registered health professionals, which include specialists like clinical psychologists who have had extensive therapy training, often to doctoral level. In order to be an accredited counsellor or psychotherapist specialised in working with children, you need to have completed training approved by the British Association of Counsellors and Psychotherapists (BACP). Other therapists, for instance practitioner psychologists (which include clinical psychologists), occupational therapists, and art therapists (specifically music, dance and drama therapists) have completed accredited training to at least degree level and are registered by the Health and Care Professions Council.

1.1 Adult–child power imbalance

When working with children in any therapeutic way, adults should be aware that children often come into therapy through referral by other agencies and carers, as you have seen in Session 6. They are therefore not necessarily entering into the relationship with a therapist through their own choice, but because adults feel they would benefit from the process.

Figure 1 Child with therapist

Children are not emancipated adults and as such they will always be part of a system which includes carers (usually their parents and other family members) and professionals (especially teachers) who make decisions on their behalf, often without sufficient negotiation with the child themselves. This means that the child can struggle to understand what is going on, especially in the case of a referral to CAMHS where the child is unaware of the depth of concern the adults in their life have about them. For example, young children are not always perceived as being competent enough to make important decisions, even around their lived experiences, but being unaware of a CAMHS referral can mean that they struggle to engage in their initial assessment, because they may incorrectly assume they are being seen in CAMHS as part of a punishment. Furthermore, children are developing and, despite being extremely adaptable as well as capable in

many respects, they are emotionally vulnerable, especially if they have had to deal with complex challenges in life such as trauma.

So, adult–child relationships within therapy can still mirror power imbalances and potential misuses of power (including abuse for some) that children may well have endured prior to entering therapy. For this reason, therapeutic work with children needs to be undertaken skilfully by suitably qualified personnel with appropriate safeguards in place to protect the child.

2 Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is a widely used evidence-based form of treatment that is used with children and adolescents, and is delivered in a developmentally appropriate way to fit with individual children's needs in terms of their cognitive, social and emotional skills.

2.1 Aims of cognitive behavioural therapy with young children

CBT works on the basis that an individual's thoughts, feelings and behaviours are all interrelated. For instance, a child might struggle to manage negative (or maladaptive) thoughts, such as ruminating about their parents dying in a volcanic eruption in the UK (where these eruptions are unheard of) which then results in the child feeling sad and anxious, to the point where they frequently become tearful. This in turn results in 'extra clingy' behaviour where the child can even become aggressive when their mother tries to leave them for fairly short periods of time. CBT, after a thorough psychosocial assessment, would then involve supporting the child to develop more positive (or adaptive) thoughts that challenge the ruminations as well as skills (such as controlled breathing) while working with the child's parents to employ behavioural strategies to treat the child's anxiety.

Figure 2 Cognitive behavioural therapy

The process usually involves a therapist working regularly with an individual child (perhaps weekly or fortnightly) often for an hour over a number of sessions. The main aim is to help modify or replace existing 'faulty thinking' and unhelpful behaviours, which in turn help to improve a child's mood and improve their functioning, hence resolving or lessening the presenting problem. The focus in CBT is therefore centred on the present rather than working through an individual's earlier life experiences (as might happen in other forms of psychotherapy).

Implementing CBT in practice

The implementation of CBT in practice involves three key stages: assessment; intervention and evaluation (Zandt and Barrett, 2017).

The ABC model is often used at the initial assessment stage as a means to make sense of the presenting issues.

- A being the activating event (i.e. what seems to trigger the behaviours/responses)
- B being the individual's belief system or attitude in relation to the event
- C being the consequences as reflected in behavioural or emotional reactions.

The key idea behind CBT is that when faced with any external event we can change our thoughts, feelings and behaviours, although this is not always easy to do, and that is why so many people have benefited from CBT as a form of therapy. As a result, we can challenge how we perceive events and look at alternative and potentially more helpful ways to view our experiences.

As part of intervention, steps D and E are included (as shown in Figure 3):

- D being the challenges/questions around the more negative, self-defeating belief
- E being the effect of challenging previous attitudes and beliefs.

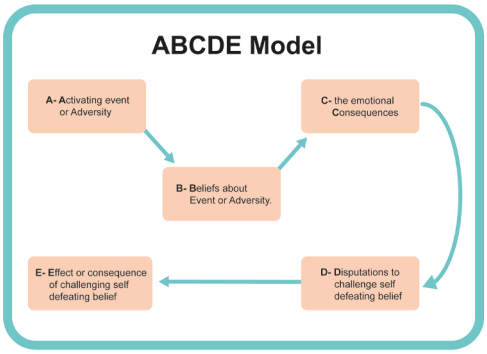


Figure 3 The ABCDE model showing cognitive behavioural therapy in adults

To help illustrate how CBT can be applied in practice, you will first be asked to think about a case study of an adult before thinking about psychotherapy with children. Any new ways of dealing with the problem that have been put into place and practised are evaluated to see how effective they have been. For example, this will include whether there have been changes in any interactions, how the person is now feeling and how they currently see themselves.

Activity 1 The ABCDE model in practice in adults

Allow about 15 minutes

Sam has been having problems at work over a number of months (**Activating event**) and things feel like they are getting worse. As a result he is feeling very low, tired and irritable (Physical and Emotional **Consequences**). As a result he has been avoiding people, especially his usually supportive family (Behavioural **Consequences**) who tend to be 'stiff upper lip' sorts. He comes home one day, after a tough day at work, when he is feeling especially low and tries to talk to his wife, Amy, about what has been going on for him.

Amy seems preoccupied and Sam gets angry (Emotional **Consequence**). He thinks 'No one ever cares about me or has time for me' ('All or nothing' self-defeating/ negative **Belief**).

How do you think Sam might start to challenge his negative thinking (step **D**)? What questions could he start to ask himself?

How might any of the responses to his questions help him to change his initial thinking (Step **E**)?

Provide your answer...

Discussion

You might have thought of some of the following in relation to questions and the ABCDE model:

- When did the issues at work begin? Was there a particular trigger or event?
- What appears to make things better or worse? Has Sam noticed improvements in his mood on, say, a Friday night (i.e. leaving work for the weekend)?
- Carefully consider the evidence. Who are the people that Sam cares about? How likely is it that none of these people care about him?
- How does he know that Amy was 'preoccupied', and how has their relationship been more generally since he has been avoiding family members?
- Who has he tried talking to about his problems so far and how does he usually go about communicating his feelings to others?
- Why might Amy be preoccupied and what has helped him and Amy to communicate about important matters in the past?

If we delve more deeply into our own negative thinking and the automatic responses and conclusions we can reach, we are more likely to find alternative ways to solve our problems. We can gently interrogate ourselves to see if our original thinking holds true.

CBT techniques can work in a similar way with older children and adolescents, using worksheets or other resources to help them to make sense of the problems they are encountering. They can talk and draw diagrams to help explain what is happening for them in different contexts and begin to understand more about how and why they react to certain triggers. They can then learn to find alternative ways to think about their problems and create their own solutions with the adult guiding them along the way.

However, how is such a focus on the way feelings, thoughts and behaviours are linked together possible with young children, who are perhaps not able to express their thoughts or feelings verbally?

In adaptations of CBT for use with children, play is used in various activities to help explain some of the issues in a simpler and more meaningful way. For example, through an activity such as using a pair of coloured glasses to look at different objects, a child can begin to understand how we might 'distort' things ourselves when we experience certain situations.

3 Play therapy

Play is, in effect, a symbolic language: a means of communication by which children can express themselves without necessarily having to use words. Through play, children can communicate their understandings and stories about their worlds and reshape their experiences as a natural way of recovering from daily emotional upheavals. Play can therefore have a very powerful therapeutic effect as a vehicle that trained personnel can use to help channel thoughts and emotions, including in very distressed young children.

Figure 4 Play therapy

Through play therapy, the practitioner enables both a structure to the session as well as the creation of a 'safe space' to work through powerful emotional reactions. The practitioner (such as a counsellor) will carefully observe the objects the child chooses to use in their play, the ways in which they use these objects and how the child interacts with the counsellor through play.

3.1 Play therapy in action

Children often find it easier to talk while they are playing. In a play-based therapy a practitioner uses a range of toys, books or other activities as a way of encouraging children to communicate their feelings and thoughts. The therapist will listen and observe the child during a play therapy session. In Session 5 you examined the importance of listening to children, the points covered included:

- the importance of listening to the 'whole child', not just what they say verbally
- keeping the child at the centre of the listening process
- allowing the child to take the lead
- how listening was related to the processes of attachment and attunement.

Attunement can be perceived as the art of reading body language, reading what the child is doing in their attempt to communicate with us. As adults, we need to feel open to what children are saying, demonstrating and expressing. Then we can affirm what they have said by repeating their expressions and body language so that we are 'in tune' with what they want us to see, rather than what we think we want for or from them.

Activity 2 Counselling children through play therapy

Allow about 20 minutes

As you listen to Christine (who is a play therapist) in the following video clips, consider how she is explaining the art of listening to children and how she allows the child to take the lead in the counselling process.

You might want to watch all the video clips at once or just dip into each as and when you want to.

Video content is not available in this format.

Video 1

Video content is not available in this format.

Video 2

Video content is not available in this format.

Video 3

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Video 4

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Video 5

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Video 6

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Video 7

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Video 8

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Video 9

After watching the video clips, note your responses to the following questions:

- How would you describe the key aspects of the counsellor's approach to working with children explained in the videos?
- In what ways does Christine suggest her role is different from other adults who might be supporting children?
- What processes were described in each of the three counselling phases Christine mentioned?
- How did Christine explain the ways in which she uses her therapy dog, Sammy?
- Which activities demonstrated by the counsellor interested you the most?
- Why do you think that was?
- How do you think children would respond to the different activities?

Provide your answer...

Discussion

In the video clips you will have noticed how Christine, the counsellor, stresses how she keeps the child at the centre of her focus and is very much guided by what the child chooses to do. Christine's role is more of a 'watchful presence', allowing the child to explore their environment and their feelings and reactions while she 'actively listens' to what they can share with her. These processes may well remind you of the role of the adult listening to children in early years' settings, as you explored in Session 5.

4 Art therapy with refugee children

Creative art-based therapies are increasingly being used to help refugee children traumatised by the effects of conflict and crisis to express their feelings and narrate their own experiences (Tyrer and Fazel, 2014).

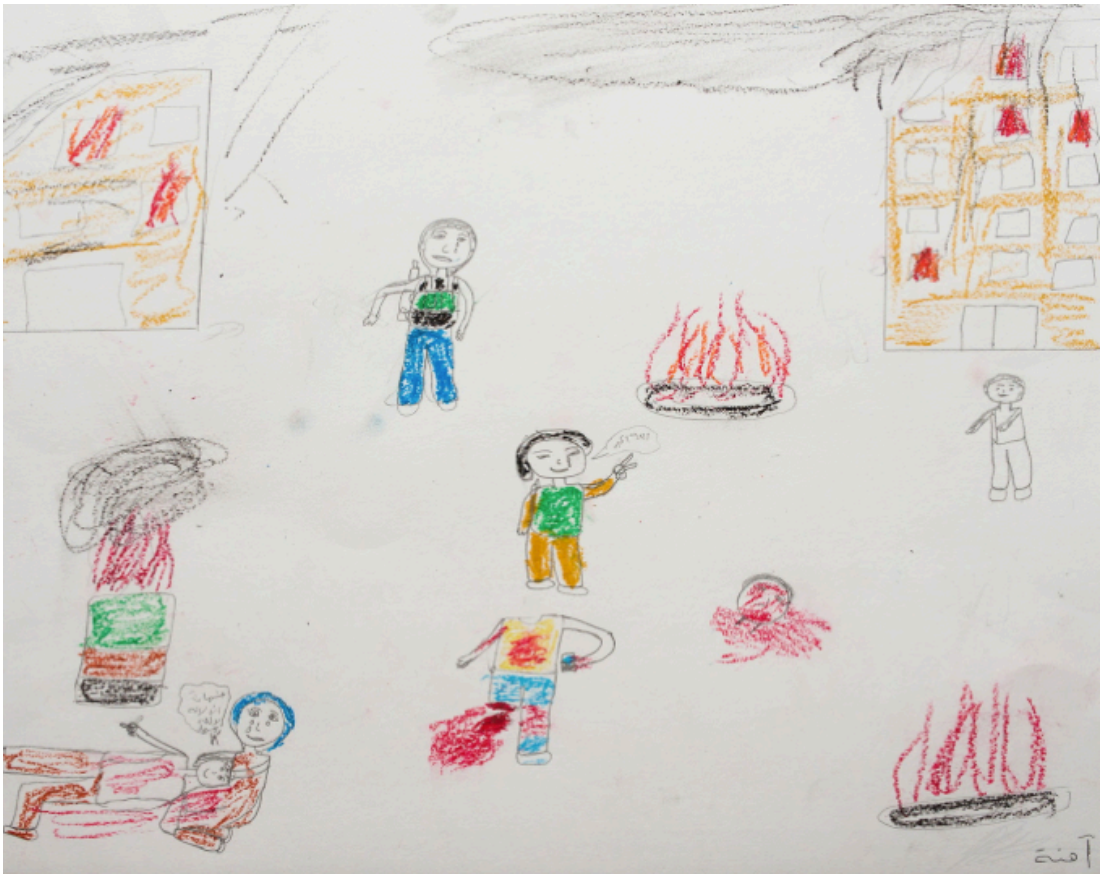

Figure 5 Illustration by a Syrian refugee child – David Gross

As you heard from the counsellor in Activity 2 and elsewhere in the course, art materials and creative processes can allow children to come to terms with emotional conflicts, develop greater self-awareness and social skills and encourage more effective coping strategies. They can help to increase self-esteem, reduce anxiety and enable children to learn various problem-solving skills.

Can you also see how use of such materials and therapy with refugee children might help them feel a sense of control over their environment, and enable them to reform a sense of who they are after experiencing the multiple losses that you read about in Session 4?

A qualified art therapy is a more recent intervention in places like Lebanon. Here is a link to a news feature about some of the positive work that is being done with children and their parents there:

News Feature on use of art therapy in Lebanon (make sure to open the link in a new tab/window)

You will notice how parents are being encouraged to mirror their child's drawings as a way of becoming more attuned to what their children are attempting to express about the experiences they have had.

5 Medication

For some children who have been diagnosed with selected mental health conditions, the symptoms may best be managed by introducing medication. Medication in the field of child and adolescent mental health is almost always recommended to be used in combination with other interventions, such as evidence-based psychotherapies like CBT. The decision to prescribe medication is a significant one and is usually only considered after a thorough assessment and when other interventions on their own are not making a sufficient difference to the child's symptoms. Medication is prescribed by a medical doctor, usually a child or adolescent psychiatrist working in CAMHS, and the decision to do so should be in consultation with the child and their parents or guardians, frequently with input from other professionals involved in the child's care.

Prescription of medication is limited in the child and adolescent mental health field, but when used it is important that the child is reviewed regularly to assess for possible side effects as well as improvements. For example, an older child with moderate or severe and persistent depressive symptoms may be prescribed an anti-depressant frequently alongside other interventions (National Institute for Clinical Excellence, 2019).

Figure 6 Child receiving medication

The most common conditions in the child and adolescent mental health field where medication is prescribed are for severe 'treatment resistant' depression, attention deficit hyperactivity disorder (ADHD) and (in older adolescents and adults) psychosis.

It is important to note that there is varying guidance about the prescribing of medication for very young children; some medication is not licensed for children below a certain age. The National Institute for Clinical Excellence (NICE) is part of the Department of Health in the UK and it produces guidance that is based on evidence about a wide range of health treatments and approaches to management.

Further information about prescribing medication for children with mental health conditions can be found in NICE guidance. You can find the details of some of this guidance in the 'Further reading' section at the end of the session.

5.1 The pros and cons of medication

There are of course pros and cons relating to the administration of drugs to manage symptoms of mental ill-health. Some medication is not prescribed, but are still 'psychoactive drugs' (i.e. is a chemical substance that changes brain function)

nonetheless. For instance, when parents give their children 'natural remedies' such as St John's wort, usually without any medical advice.

Activity 3 The advantages and disadvantages of medication for children with mental illness

Allow about 15 minutes

Consider the pros and cons, or advantages and disadvantages, of prescribed medication when recommended by a medical doctor for a child who has been diagnosed with a mental health illness. Think about the possible advantages and disadvantages for the child, the family, their education setting.

Figure 7 Examining the different perspectives of prescribing medication

Provide your answer...

Discussion

Here are some of the advantages and disadvantages of prescribing medication. You may have identified others.

The child

Advantages: Prescribing medication can help to address symptoms or features of a disorder and enhance a child's functioning. For example, a child who has been diagnosed with attention deficit hyperactivity disorder (ADHD) after a comprehensive assessment across a range of environments, including their home and school, may find that medication, in particular Ritalin, can help to reduce their impulsive behaviour. Burton et al. (2014) illustrate this point by recounting their experience of working with children who report that an advantage of taking medication in this context is that it gives them 'thinking time' (p. 30), meaning that the medication can help increase their concentration. Increased concentration can help children to better engage with their education and learning.

Disadvantages: Not all medication works in the same way, and for some conditions efficacious medications are not available. Plus, we are all individual and dosage and personal preferences are important. Unfortunately, it is not uncommon for medications to cause side effects. This is why, prior to being prescribed a medical doctor will do a

careful 'cost-benefit analysis' to determine whether the possible advantages (or benefits) clearly outweigh the costs (such as the side effects). Children who have been prescribed medication for ADHD may experience sleep problems, headaches and mood swings (National Health Service, n.d.). But without their medication they may struggle to function adequately, disrupting their learning and negatively impacting on their relationships with others.

When medication is having a positive impact there are also disadvantages. A compromise may be reached by introducing what Pavord et al. describe as treatment 'holidays' (2014, p. 30). This is where, for example, the child may take a break from medication when they are not at school.

Parents

Advantages: Having a child with a mental health condition can be distressing for parents and the whole family. The symptoms of a mental illness can have a profound impact on parents, who frequently blame themselves for their child's diagnosis, which can be difficult for them to manage. Prescribing medication occurs infrequently with younger children, and should always be done when it is in the best interests of the child. Reducing symptoms and improving functioning as a result of medication can mean that parents will experience less pressure and in turn it makes parenting a 'challenging child' less difficult. Reducing the pressure on the family can help make a positive contribution to the wellbeing of parents and other siblings.

Disadvantages: Parents may find that medication, in particular the treatment adherence associated with it, becomes an added task which requires extra effort and time. This can include remembering to order the medication, administering it suitably, liaising with the child's education setting and taking the child to review appointments. Some parents may have cultural or religious beliefs that mean they are reluctant for their child to receive medication, and many parents will be opposed to their child taking medication because they would prefer talk-based therapy.

Education

Advantages: If the medication assists the child, in terms of their functioning, this can mean that the child is able to more fully participate in their education setting. This has advantages for the child, and potentially for other children and for the staff.

Disadvantages: Staff may need to be aware of potential side effects of medication. Learning about this will require time to access training and to be able to liaise with parents. Some medication is formulated so that it can be given at home; however, this may not always be the case, therefore a medication policy will need to be written. Consideration will need to be given about the storage and administration of medication and who at the school is responsible for this.

Prescribing medication needs to be a joint decision, as far as possible. It is important to review the impact of the medication and to weigh up the pros and cons. Of course, not all medication is prescribed – 'natural remedies' purchased over the counter also carry risks, and there is limited evidence to support their effectiveness.

6 Trauma-informed schools

The UK government's green paper 'Transforming Children and Young People's Mental Health Provision' states that:

> There is evidence that appropriately-trained and supported staff such as teachers, school nurses, counsellors, and teaching assistants can achieve results comparable to those achieved by trained therapists in delivering a number of interventions addressing mild to moderate mental health problems (such as anxiety, conduct disorder, substance use disorders and post-traumatic stress disorder).
>
> (Department of Health and Department for Education, 2017)

Therefore, a growing body of training for staff is now becoming available to help develop more effective strategies for dealing with various mental health issues in children and young people. Staff are also being encouraged to become more vigilant (on the alert) and proactive (prepared to act) in response to potential triggers and stresses that might lead to mental health problems.

You have already examined many of the issues that affect children's mental wellbeing throughout the course so far. Can you recall some of these?

You may have thought of the following:

- bullying
- loss, including the death of significant carers, siblings, friends
- parental separation
- physical, emotional and sexual abuse
- neglect
- personal and family illness or disability
- frequent house moves
- living in poverty
- lack of financial stability and resources at home.

Trauma-informed practice means that everybody within an organisation such as a school – from administrators to governors, teachers and parents – can understand, recognise and respond to the effects of all types of trauma.

You might like to look at the following website to see the kind of training that might be involved, and how such training relates back to many of the issues around supporting children's mental health and wellbeing that have been addressed in this course to date:

Trauma informed schools (make sure to open the link in a new tab/window)

Activity 4 Trauma-informed practice

Allow about 10 minutes

Watch the two clips of Christine describing her personal journey from teaching in school to counselling children.

As you watch the clips, reflect on what Christine found difficult about the school system, and how perhaps with more effective training in trauma-informed practice as

discussed previously in this session, the situations Christine described might be better supported.

Video content is not available in this format.
Video 10

Video content is not available in this format.
Video 11

Provide your answer...

7 Parenting programmes

You may have heard the comment that, unlike items such as a washing machine, babies do not arrive with an instruction manual. Professional support for parenthood is part of the antenatal care available to pregnant women, and included in antenatal care are practices that are aimed at maximising the chances of strong attachment bonds forming between the baby and parent(s).

Every child born in the UK has a health visitor assigned to them. Part of the health visitor role is to provide support and guidance to parents about their children's health and development. Session 6 included some information about the role of the health visitor.

Despite the professional support that is available, a shortage of services in some areas and other factors can mean that some parents find parenting a challenge and would benefit from further support. An area of challenge for many parents is their children's behaviour. Many parents struggle when their children's behaviour is deemed to be unacceptable both by themselves and others. Support for such parents is available via parenting programmes. However, the reduction in the number of children's centres has affected the availability of such parenting courses in many areas. Furthermore, professionals need to be careful that deficit models of parenting are not the focus of support programmes and workshops. Deficit models can make parents feel inadequate and undermine perceptions of the family as a whole system with varying strengths, weaknesses and levels of resilience.

7.1 Evaluating parenting programmes

Burton et al. (2014) summarise the key objectives of parenting programmes, which are to:

- promote positive parenting
- improve parent–child relationships
- help parents to manage their children's behaviour
- reduce the need for discipline and increase the use of positive strategies.

There are several parenting programmes which have been evaluated positively and are evidence-based, such as 'The Incredible Years'. Programmes such as this one have proven to show significant improvements in children's behaviour and these 'parent management training' interventions are the treatment of choice for children with conduct disorder. A Public Health England (2014) publication includes more information about parenting programmes. There are features of parenting programmes that are essential for the programme to be effective and have a positive impact on the child and family:

- **group based:** giving parents the opportunity to discuss and learn from each other.
- **strengths based:** all parents have strengths, and these should be identified and built upon.
- **use of a manual:** parenting programmes should have a manual that is referred to and used in the classes.
- **homework:** parents should have tasks to carry out at home to reinforce messages from the parenting classes.
- **role play:** opportunities to practise skills.

8 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 5 Session 7 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do before the next session?

Provide your answer...

9 This session's quiz

Well done – you have reached the end of Session 7. You can now check what you've learned this session by taking the end-of-session quiz.

Session 7 practice quiz

Open the quiz in a new tab or window and come back here when you have finished.

10 Summary of Session 7

In this session, you have focused on various interventions that can be useful when trained specialists work with individual children and their parents in helping to improve children's mental health and wellbeing. You have also seen how prescribed medication can sometimes be administered but needs to be undertaken very carefully according to clinical guidelines, such as those developed by NICE. There is also a growing acceptance that children's wellbeing needs to be the responsibility of everyone who works or is involved with children in a variety of settings, and at different levels within an organisation.

You should now be able to:

- recognise how the power imbalances between child and adult can affect the therapeutic processes
- understand what is meant by cognitive behavioural therapy (CBT)
- appreciate the role of play and creativity in counselling and therapy with young children
- realise some of the challenges associated with prescribing medication to treat a child's mental health condition
- understand how parents might be helped to manage children's behaviour and support their wellbeing.

In the next session, which is the final session of the course, you will be examining the effects of technology on children's mental health. You will also review the key messages you have hopefully gathered from all of the sessions in this course.

You can now go to Session 8.

Session 8: The influence of screen time on young children's mental health and wellbeing

Introduction

Much has been written about the impact of screen time and the internet on very young children. As the course draws to a close, you'll start the final session by looking at the influence of screen time and the internet on young children's lives, and consider the potential physical and mental health effects. You'll start to explore some of the ways that we can support children to develop healthy habits in relation to the use of electronic devices and access to the internet and, for older children and adolescents, social media. You'll also review the systems around children and look at the responsibilities of all who work and care for young children, not just in relation to managing their access to screen time, but also to supporting children's mental health in broader terms.

Now listen to the audio introduction to this session.

Audio content is not available in this format.
Audio 1

By the end of this session, you will be able to:

- explain why it is important to support young children to develop healthy approaches to screen time
- summarise the ways that the systems around children can support their mental health and wellbeing
- identify your role in supporting young children's health and wellbeing.

1 Screen time and internet use in the early years

Figure 1 Children's use of screen time

Screen time can be defined as the time spent using a device such as an electronic tablet, computer or games console, as well as time spent watching television. Children increasingly have access to the internet via mobile devices, and many older children also access social media via the accounts of other people known to them. This course is focused on children aged 0–8 years; however, Glazzard and Mitchell (2018) have previously estimated that as many as 'one in four of 8 to 11 year olds have a social media profile' (p. 7). This suggests that children become interested in social media and are accessing and engaging with the internet before the age of 8. Therefore, it is important to start educating children from a young age to prepare them to be able to develop healthy ways of using the internet and, when older, social media.

In relation to children aged 0–8 years, it is reported that very young children are being exposed to screen time because they are using electronic devices. This relatively new phenomenon of babies and toddlers using electronic devices is causing alarm because of the concerns that screen time is affecting young children's health. In response to such concerns, the World Health Organization (WHO) (2019) issued guidelines on physical activity, sedentary behaviour and sleep for children under 5 years of age. The guidelines state that babies under one should not have any screen time and children aged 3–4 should be limited to one hour per day.

However, the WHO guidance has not been endorsed by the National Health Service (NHS). Instead, the NHS give a measured response on their website (NHS, 2019) including comments from academic experts who state that the research evidence to support the WHO guidance is not robust. You can find out more on the NHS website:

Guidelines issued on activity and screen time for babies and toddlers (make sure to open the link in a new tab/window)

This lack of agreement between WHO and the NHS about how much screen time children under 5 should have is unhelpful to parents and professionals who are responsible for educating and bringing up children in a digital world. However, it stands to reason that if children become interested in and, in some cases even potentially dependent on, the use of electronic devices from a very young age, then they are less likely to be engaging with physical activity, which can therefore lead to a higher level of sedentary behaviour. It is suggested that higher levels of sedentary behaviour are associated with childhood obesity

(Public Health England, 2019). It is also likely that engaging with screen time from a very young age will 'fuel' children's interest in the internet and also social media as they grow older.

As stated previously, many children are thought to be using social media from the age of 8, even when a young person has to be at least 13 years old before they can have an account for TikTok, Facebook and Instagram. Therefore, social media is featuring in the lives of many young people – for better or for worse – and this in turn may have an impact on their mental health. The influences of social media are suspected of being mostly negative, so this session aims to outline some of the concerns about social media and the risks it can pose to children's mental health, as well as outlining some of the possible positive influences.

Look at the statistics in the infographic in Figure 2. It's a snapshot of children's digital lives (Ofcom, 2017).

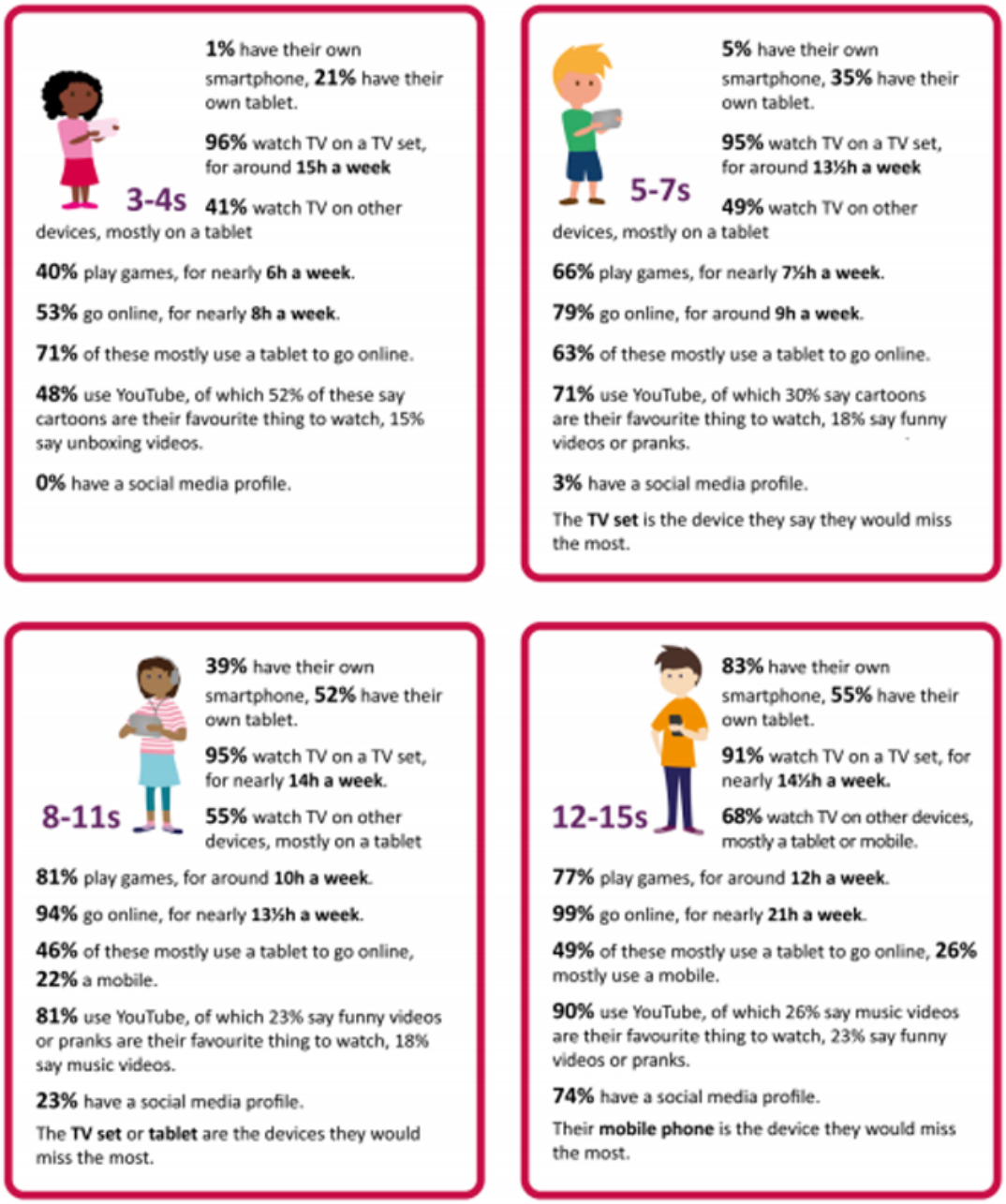

Figure 2 Children's digital lives

1.1 The risks of social media for children

The effects of social media on older children's mental health is of concern, which has been borne out by research by Viner et al. (2019).

Figure 3 The effect of cyberbulling on children

Activity 1 Identifying the risks of social media for young children

Allow about 5 minutes

Make a list of the ways that you think social media, and the internet more generally, can be unhelpful in relation to children's mental health and wellbeing.

Provide your answer...

Discussion

The possible impacts of social media and the internet on children's mental health might include:

- The effect of being exposed to cyberbullying or receiving inappropriate unsolicited messages from adults who are strangers.
- Being able to access problematic websites that promote self-harm and eating disorders. Seeing such information can normalise behaviours for children when they are particularly impressionable.
- An increased risk of developing poor body image because the constant use online of 'beautiful' bodies is thought to be linked to lower body esteem and body surveillance (Frith, 2017).
- A greater risk of being exposed to pornographic material and content that promotes violence and intolerance.
- Addiction: children who spend a great deal of time on social media, and the internet more generally, run the risk of becoming addicted to its use. Hoffmann et al. have gone as far as to assert that 'social media is more addictive than cigarettes and alcohol' (cited in All Party Parliamentary Group, 2018, p. 66). But it is worth remembering that something can be highly addictive (like caffeine) and not have major negative consequences in the same way as alcohol and other drugs.

As well as affecting young children's mental health, social media can impact on physical health because:

- The lack of sleep that children and young people experience when using the internet and social media late into the night can lead to tiredness, irritability and a general lack of energy.

- Engaging with the internet and social media can mean that there is less time for taking exercise, so children are being deprived of the positive effects on wellbeing that are associated with exercise.

Viner et al.'s (2019) findings, which were published in *The Lancet: Child & Adolescent Health* journal, were taken from a study carried out involving 866 children aged 13–16 in England. They concluded that children who 'frequently use social media' (defined as 'used multiple times daily') are significantly more likely to experience mental health problems, and that the situation is probably worse for girls than it is for boys. The researchers suggested that exposure to cyberbullying or displacement of sleep or physical activity as a result of very frequent social media use could explain the increased risk. The findings from Viner et al.'s study highlight the importance of ensuring that early work occurs to help avoid the negative impact of social media on children's mental health. Such interventions should include measures to increase resilience to cyberbullying, as well as ensuring children receive adequate sleep and physical activity. You will return to these points later in this session.

Although the negative effects of screen time, including social media use, are discussed extensively, it is important to consider the benefits of screen time, the internet and social media for older children. You will look at this briefly in the next section.

1.2 The benefits of the internet and social media for children

Using the internet can open channels of communication that were previously unavailable to people. For those who live in remote areas of the world, who have a disability, are from a minority group (for instance intersex children who are born with Variations of Sex Characteristics) or have other restrictions on how they access information, the internet is a rich and important resource. It gives access to information that is beneficial and useful, and it also allows them to connect with others like themselves so that they can develop knowledge and understanding of the world around them.

Figure 4 Using the internet as a way of accessing knowledge

Young children have been born into a world where the internet is a taken-for-granted resource. However, the internet has only been around for the last 25 years or so and for many adults, it is still a source of wonder. Because it is relatively new, and because the ways that we can use the internet are continuously evolving, it can be tricky to know how

to teach and guide children about its use. Clearly, the digital world is not going away, so it is important to identify ways that we can work together to support children and teach them how to harness the positive effects of living with screens and accessing the digital world.

1.3 Working together to manage children's screen time

Concerns about the impact of the internet and social media on young children's mental health are common in countries where children and young people can easily access electronic devices, the internet and social media. Society has a shared responsibility to guide children to develop healthy ways of using electronic devices and accessing the internet, ensuring that screen time does not become 'digital babysitting' and overused. You'll now look at this responsibility from the different perspectives of all involved.

Governments around the world: In England, there is work in progress to produce an internet safety strategy (Her Majesty's Government, 2018), which will set out more detailed measures to address harmful and illegal online content. This will include proposals on a social media code of practice and online advertising.

Health service guidance: There is a need for screen time to be a public health issue and responded to in a similar way that other activities that potentially damage health are approached. The Chief Medical Officer (2019) has published a commentary on the use of children's screen time, as has the Royal College of Paediatrics and Child Health (2018).

Pre-schools and schools: All policies need to include health promotion messages relating to managing screen time, promoting physical health and ensuring pre-school children get adequate sleep.

Parents and families: Of course, parental and caregiver supervision of screen time usage is very important, but in addition to this, the previously mentioned Chief Medical Officer's commentary (CMO) (2019) suggests that parents need to examine their own behaviour in relation to how much time they spend on screens. The CMO includes the following discussion questions, produced by the Royal College of Paediatrics and Child Health, to help families make decisions about their screen use:

- Is your family's screen time under control?
- Does screen use interfere with what your family want to do?
- Does screen use interfere with sleep?

Activity 2 How can you manage children's screen time?

Allow about 15 minutes

The following points are taken from the Royal College of Paediatrics and Child Health (RCPCH) report (2018), which includes guidance taken from the American Academy of Paediatrics (2016). Consider whether these points are relevant to the children you work with or care for. (For children younger than 18 months, avoid use of screen media other than video chatting.)

- Parents of children 18 to 24 months of age who want to introduce digital media should choose high-quality programming and watch it with their children to help them understand what they're seeing.

- For children age 2 to 5 years, limit screen use to 1 hour per day of high-quality programs. Parents should co-view media with children to help them understand what they are seeing and apply it to the world around them.
- For children age 6 and older, place consistent limits on the time spent using media, and the types of media, and make sure media does not take the place of adequate sleep, physical activity and other behaviours essential to health.
- Designate media-free times together, such as dinner or driving, as well as media-free locations at home, such as bedrooms.

Provide your answer...

Discussion

Were you surprised by any of the above points? Have you identified a point that you feel needs to be addressed in relation to the children you work with or care for? Do you think there are difficulties or barriers to working with this guidance?

You may think that managing children's screen habits needs to start very early in childhood; if so, you are absolutely correct. In the same way that children need to be supported in learning about their behaviour in all aspects of life, they need to be taught about safe and healthy ways of using the internet and social media. Children need support to develop their digital habits so they reflect respect for others. In this way, the negative impact of using the internet and social media can be reduced.

Clearly, there is a need for an international agreement about consistent and robust guidance relating to safe levels of screen use for children. In addition, more reliable research and support needs to be available for parents to help them understand the importance of developing healthy habits in relation to screen time.

Figure 5 Limiting access to screens for babies is important for their health

From a one-day event on research, policy and communication in a digital age, Jon Sutton (2018) reports on the need for better research on the whole topic of screen time use by children to better inform parents.

What do parents want from us as psychologists? Tamsin Greenough Graham represented the Parenting Science Gang, 2000 parents united by a desire to have scientific evidence to drive parenting. She said that a common fear among parents is the judgement of other parents and healthcare professionals, many of whom ask: 'how long does your child spend in front of screens each day?' In determining whether it's a problem, Greenough Graham said: 'We don't know those answers. The information has not been made

available to us, at least in a way we can use it.' But she also reported that parents want to know the benefits of screen time, and what screen time life skills we need to teach our children: 'If our children were off playing with LEGO during that time, none of us would feel guilty. We value LEGO. What is there to value about screen time? Tell us.'

To read more about this subject, see the links in the 'Further reading' section at the end of the session.

On a final, more optimistic note, you may now be aware that there is a great deal of work that can be done to educate very young children about the impact of inappropriate use of social media. As you have seen, the use of electronic devices (like gaming) has been found to be addictive, while at the same time having positive benefits. So, it is important that good habits are developed in very early childhood. Parents also need to be supported to help them implement restrictions as well as optimise the use of technology so that children are better prepared to engage more positively within various digital environments.

In this section, you've seen that supporting children to develop good screen time habits is important in order to lay the foundations for the use of the internet and social media in later childhood.

You've also seen that managing children's access to social media cannot be solely a responsibility for government. There is an urgent need for adults – especially parents and professionals who work with children – to devise approaches to manage and limit children's access to social media. In addition, there is a great deal of work that can be done to educate very young children to learn about the impact of inappropriate use of social media, and help them increase more positive engagement with new technologies they encounter in the current digital age.

In the next section, you will review the content of previous sessions and summarise the key points. These key points will be useful as you complete the final quiz at the end of the session to earn your badge.

2 Reviewing the way that the systems around the child support mental health

In the final part of the course, you will review some of the main points from the previous sessions.

As you saw in Session 1, over time some children have always been affected by mental ill-health, but it has only recently been recognised as such.

In the following sections, you will review some of the content of the previous sessions and summarise the roles and responsibilities of individuals within each of the systems in promoting good mental health in children.

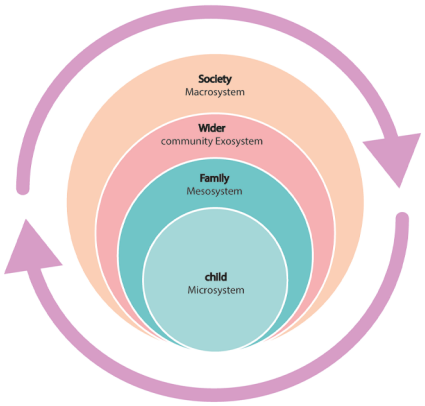

Figure 6 Systems around the child (adapted from Bronfenbrenner, 1979)

2.1 Within the child

It is crucial to view mental health concerns at an individual level, since not all children react or respond in a similar way. It is also important to look beyond the often generalised and negative issues raised by concerns such as the impact of the internet and social media on children's mental health. However, the presence of some factors in the immediate system around the child are clearly beneficial to promoting good wellbeing and good mental health.

Play is an integral aspect of the everyday life of very young children. As you've seen, giving children opportunities to engage with play in different contexts is vital. Ensuring that children have access to outdoor play and activities is also highly beneficial in promoting wellbeing.

Figure 7 Children need to play

You have considered the importance of giving children opportunities to develop resilience so they can thrive and develop self-esteem and confidence. Children can develop resilience in the face of adversity, especially if they have support from their family and professionals, such as teachers.

2.2 Within the family and parents

Parents need to be able to access good antenatal care and to receive appropriate support with parenting. Parenting support can help to promote children's wellbeing and make a positive contribution to their mental health; this can prevent problems from developing.

Figure 8 Supervision of screen time for young children

As you saw earlier this session, excessive screen time is appearing to have some negative effects on young children, so parents need to be supported to introduce safe ways for their children to engage with the digital world.

2.3 Within the wider community

The wider community includes the local neighbourhood and services. For example, children's centres provide parenting classes, play services and early education and they make a positive contribution to supporting children's mental health and wellbeing. However, many children's centres have closed since 2010, leaving a gap in the services available in the wider community.

Figure 9 Access to playgrounds helps with children's wellbeing

Local neighbourhoods: safe outdoor areas with well-maintained parks and playgrounds can make a positive contribution to children's wellbeing. Being outdoors and engaging with others can also help to reduce children's screen time (All Party Parliamentary Group, 2019).

Professionals delivering children's services: there is a need to promote knowledge about children's mental health as well as greater understanding of the ways that children's wellbeing can be improved. In relation to very young children, educators in pre-school and school settings can make a positive contribution to supporting children's mental health and wellbeing. Early childhood and primary curricula have many strategies that can make a positive contribution. High-quality early education is especially important; for instance, the key person helps young children to develop a relationship with practitioners who know the children's needs and, in negotiation with parents, can help identify how best to meet such needs. High-quality early education and care requires adults to listen to how children express themselves, both verbally and non-verbally, so that the children's voices can be taken into account in all decision-making affecting their lives.

2.4 The role of society

Of course, each individual child and adult is a member of society. Therefore, it can be argued that everyone has a responsibility to support children's mental health and wellbeing.

There are many ways that such support can be demonstrated, for example:

- Increased understanding of the critical 0–2-year period of life and how good foundations for the future are laid down when parents and young children have loving relationships and strong attachments. In line with this suggestion, there needs to be funding for high-quality early education for children.

- Adopting the messages in the United Nations Convention on the Rights of the Child, listening to children and taking their views into account.
- Creating safe environments for children to be able to explore and enjoy both indoor and outdoor play activities.
- Changing attitudes towards children so that there is increased tolerance for children.

There is a pressing need for government to support the creation of a curriculum that is not only suitable for children's age and stage of development, but one that can increase children's autonomy as well as enhance their creativity and wellbeing.

The Department of Health and Department for Education's green paper 'Transforming children and young people's mental health provision' (2018) is a significant contribution to reacting to the number of children being diagnosed with mental health conditions. The green paper promotes an integrated and holistic approach to addressing the problem. One proposal is for schools to have a designated senior lead for mental health in schools by 2025. There will be a need for high-quality training to equip staff to be able to identify children with mental health problems and know how to support them in schools.

3 The future

As parents and/or professionals working and caring for children, increasing our knowledge of how to prevent some of the issues that can contribute to poor mental health and mental illness is a positive step to take. It is important to keep in mind the 'recipe' for emotional wellbeing and the holistic nature of children's health and wellbeing. While funding for children's services to improve wellbeing and mental health is important, as well as having high-quality professionals, it needs to be kept in mind that many of the ingredients in the recipe relate to how well we develop relationships with children, and we can all do more to develop and maintain those relationships.

Figure 10 Supporting children's wellbeing

The final section includes some useful resources for anyone with an interest in children's health and wellbeing.

4 Resources for parents and professionals

This section includes some resources that are available for parents and professionals:

Action for Children: Children's mental health

Barnardos: Adverse Childhood Experiences

National Institute for Clinical Excellence (NICE): Social and emotional wellbeing for children and young people overview

Public Health England: The mental health of children and young people in England

Time to Change: Mental health resources for schools and parents

Young Minds: Resources

5 Personal reflection

At the end of each session, you should take some time to reflect on the learning you have just completed and how it has helped you to understand more about children's mental health. The following questions may help your reflection process each time.

Activity 3 Session 8 reflection

Allow about 10 minutes

1. What did you find helpful about this session's learning and why?
2. What did you find less helpful and why?
3. What are the three main learning points from the session?
4. What further reading or research might you like to do now that you've finished this course?

Provide your answer...

6 This session's quiz

It's now time to complete the Session 8 badged quiz. It is similar to the previous quizzes but this time, instead of answering 5 questions there will be 15, covering Sessions 5–8.

Session 8 compulsory badge quiz

Remember that the quiz counts towards your badge. If you're not successful the first time, you can attempt the quiz again in 24 hours.

Open the quiz in a new tab or window by holding down Ctrl (or Cmd on a Mac) when you click the link. Come back here when you are done.

7 Summary of Session 8

Children's mental health is a cause for global concern. It is thought in England alone that 10% of children aged 5–16 have a diagnosable mental health disorder that will require professional support. However, many causes that can lead to compromised mental health in children can start at conception, and it is important not to overlook the importance of the 0–2 year age group. Therefore, we need to increase awareness of how good mental health can be promoted in early childhood.

It is important that adults – both parents and professionals – are equipped to understand, identify and become more knowledgeable about the prevention and causes of children's mental health. Increasing knowledge and understanding of the role of adults in supporting children's mental health is vital to reverse the trend of increasing numbers of children who are being diagnosed with a mental health condition.

You should now be able to:

- explain why it is important to support young children to develop healthy approaches to screen time
- summarise the ways that the systems around children can support their mental health and wellbeing
- identify your role in supporting young children's health and wellbeing.

Where next?

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Tell us what you think

Now you've come to the end of the course, we would appreciate a few minutes of your time to complete this short end-of-course survey (you may have already completed this survey at the end of Session 4). We'd like to find out a bit about your experience of studying the course and what you plan to do next. We will use this information to provide better online experiences for all our learners and to share our findings with others. Participation will be completely confidential and we will not pass on your details to others.

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Further reading

Cruse

Young Minds

If you would like to study attachment in more detail, you might find the following OpenLearn course interesting to explore: Attachment in the early years

You might also find the following links useful:

Parent Infant Partnership UK today

Zero to Three

Parliament UK (2018) Science and Technology Committee: the Evidence Behind Early Intervention

Wave trust

For further information and resources about some of the work that has been carried out to highlight the mental health of children and their families, see the following resources and publications:

Anna Freud National Centre for Children and Families. Supporting young people's mental health during periods of disruption

Save the Children 'Invisible Wounds', reports on the impact on children of six years of war in Syria

StreetInvest and the University of Dundee report on their research 'Growing up on the Streets'

StreetInvest, 'Growing up on the streets: A Story Map by Accra's Street Youth'

StreetInvest, 'Growing up on the streets: Health and wellbeing of street children and youth'

The UN Refugee Agency (UNHCR) 'is a global organisation dedicated to saving lives, protecting rights and building a better future for refugees, forcibly displaced communities and stateless people'.

The Open University is working together with other universities. The project is called Children Caring on the Move.

England: Statutory framework for the early years foundation stage

Northern Ireland: Curricular Guidance for Pre-School Education

Scotland: The Early Years Framework

Wales: Foundation Phase Framework

British Association of Counsellors and Psychotherapists (BACP)

Department for Education: Helping parents to parent

Inside Outside project. Illustration by a Syrian refugee child from the Inside-Outside art and therapy outreach programme for refugee children (Middle-East and Europe) founded in 2013 by David Gross, photographer.

NHS: Cognitive Behavioural Therapy

National Institute for Clinical Excellence: Antisocial behaviour and conduct disorders in children and young people: recognition and management

National Institute for Clinical Excellence: Children and Young People's Mental Health: how NICE resources can support local priorities.

Attention deficit hyperactivity disorder: diagnosis and management. See page 41 for information relating to children under 5.

Public Health England Local action on health inequalities: Good quality parenting programmes.

Trauma Informed Schools

To find out more about how to take into account the differing positive and negative views about screen time discussed in the course, you could read this article:
Seeing screen time differently

Also see the British Psychological Society's Briefing Paper (2018):
Changing behaviour: children, adolescents and screen use

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