



Royal College
of Nursing

Mental health in children and young people

*An RCN toolkit for nurses who are not mental
health specialists*





Acknowledgements

We would like to thank Sue Sylvester, Independent Nurse Consultant, for revising this publication in conjunction with the following people who have assisted in the development and review of this document by sharing their knowledge and expertise:

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This publication is due for review in September 2016. To provide feedback on its contents or on your experience of using the publication, please email publications.feedback@rcn.org.uk

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Published by the Royal College of Nursing, 20 Cavendish Square, London W1G 0RN

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Introduction

Improving the social and emotional welfare of the whole population is enshrined in the documents and policies of all four countries of the United Kingdom and the responsibility of interagency and interdisciplinary working is highlighted in these documents.

Nurses have both an ethical, as well as legal duty of care to report concerns they may have about mental health issues of the children and young people they come into contact with and should be cognisant of Article 24 of the United Nations Convention on the Rights of the Child: "... children have the right to good quality health care – the best health care possible...". One in 10 children aged between five and 16 years has a clinically diagnosable mental health problem. Just over half of these children and young people (5.8 per cent) have a conduct disorder; 3.7 per cent an emotional disorder (anxiety, depression) and one to two per cent have severe attention deficit hyperactivity disorder (ADHD) (ONS, 2004). Twice as many boys aged between five and 10 years are diagnosed, in comparison to girls (ONS, 2004). Half of those with lifetime mental illness (excluding dementia) first experience symptoms by the age of 14, and three quarters before their mid-20s.

The prevalence of these problems increased between the 1970s and the 1990s (Collishaw et al 2004) and there is a high degree of persistence of these problems into adult life (Rutter et al., 2006). Evidence already suggests that these problems have a serious impact on life chances (for example, Ferguson et al., 2005; Colman et al., 2009). To ensure that provision meets demand the Chief Medical Officer Report, states 'the imperative that data are collected on the prevalence and incidence of mental health conditions and an annual audit of services and expenditure in the area undertaken' (DH, 2013).

Early recognition and referral can make a positive difference to the child and family, in both the short and longer term (RCN, 2004). The period between pregnancy and three years is increasingly seen as a critical period in shaping life chances, based on evidence of brain formation, communication and language development and the impact of relationships formed during that period on mental health. The case for early intervention including perinatal and infant mental health is well recognised in relation to promoting a foundation of resilience and thus improving mental health outcomes (Allen, 2011).

However, identifying mental health problems and responding appropriately can prove challenging for nurses working with children and young people.

Most children with mental health problems are managed outside specialised mental health services. Consequently, all health care staff should have an understanding of how to assess and address the emotional wellbeing of children and young people. They should be able to recognise if a child or young person may be suffering from a mental health problem and liaise with the appropriate services (DH, 2007). Mental health promotion should be an underpinning principle for all who come in contact with children and young people, whether they are well or unwell (Public Health Institute of Scotland, 2003).

"Nurses, health visitors and midwives work across a range of settings, and are one of the largest groups of health care professionals who come into contact with children and young people. They are in the right place to promote the psychological and emotional well being of children and families and to prevent the development of mental health problems by being aware of the factors that can put children and young people at risk" (DH, 2003; DfES, 2003).

Our aims

This document aims to assist those nurses who are not mental health specialists who work with children and young people in community, hospital and other settings. It will help them in identifying the skills and knowledge they need to recognise and, if necessary, refer children who have problems affecting their mental health. It will also help those nurses who provide care in acute hospitals, while waiting for specialist mental health practitioners to attend a particular child or young person, by giving insight into the more common mental health problems and facilitating the development of local guidelines.

In addition, this publication will be of use to those who are preparing education and training programmes to assist nurses in their understanding, recognition and management of mental health problems in children and young people.

What this document includes

The document gives brief outlines of the common mental health problems that practitioners may identify in various community or hospital settings, including GP practices, school nursing services, looked after children, community children's nursing, accident and emergency departments, outpatient services, acute children's wards and youth offending services.

It provides basic information on the knowledge and skills nurses need in order to recognise and care for children and young people who present with possible mental health problems.

Further, it includes references, organisations and websites that nurses may find useful for developing their knowledge. Some of these are specific to the four countries of the UK.

It can be linked to the following NHS Knowledge and Skills Framework dimensions:

- HWB1 (promotion of health and wellbeing and prevention of adverse effects on health and wellbeing)
- HWB3 (protection of health and wellbeing)
- HWB4 (enablement to address health and wellbeing needs)
- HWB6 (assessment and treatment planning)
- HWB7 (interventions and treatments).

Further information can be obtained from www.skillsforhealth.org.uk

What this document does not include

The document is **not** aimed at nurses working in child and adolescent mental health services (CAMHS) who have specialist expertise. Nor does it replace the need for the inclusion of specific training in children and young people's mental health, in either pre- or post-registration education programmes. However, it will assist nurse educators in preparing programmes.

What nurses should know

There is a raft of evidence relating to this topic and useful background information, for example the *National Service Framework (England)*, *Marker of good practice for Standard 9* states "All staff working directly with children and young people should have sufficient knowledge, training and support to promote psychological wellbeing of children, young people and their families."

Nurses at the frontline of service delivery for children and young people are often best placed to recognise when the child or young person is experiencing difficulties. They should be able to offer general advice and treatment for less severe problems; contribute towards mental health promotion; identify problems early in their development; and refer to more specialist services. (*Every Child Matters*, DfES, 2004a). Nurses will need to ensure that they are aware of local referral protocols to services as services will vary in localities. With support and training, they will be able to provide screening and some simple interventions with young people and their families.

It is generally regarded as important for all children's health care staff to undergo education and training in how to recognise and respond appropriately to the mental health needs of children, and to be able to support their families. To do this effectively, nurses need to ensure they have good knowledge of how children and young people develop socially, emotionally and psychologically, and the risk factors that can lead to mental health problems.

MindEd, an e-learning portal is being developed to support young healthy minds and will be available from spring 2014. This programme aims to provide a single source of e-learning materials, including content that covers the breadth of children and young people's mental health. The RCN along with a number of other Royal Colleges, is one of the member organisations supporting this development (www.minded.org.uk).

The skills and knowledge necessary for identifying potential mental health problems are described in document MH14 of competences developed by Skills for Health, the health sector's skills council (www.skillsforhealth.org.uk). In particular, they include the need for a working knowledge of:

- how to assess and manage the risks (for example, physical harm, but risks such as risk to a young person's educational prospects or their peer relationships should not be overlooked), to individuals, self and others
- the range of different mental health needs and their effects.

Good mental health

Mental health is everyone's business. As *No health without mental health* states, "good mental health and resilience are fundamental to our physical health, our relationships, our education, our training, our work and to achieving our potential" (DH, 2011). The mental health of the child, young person and their family should be an integral part of all children's services, not overlooked when a physical health disorder takes priority (DH, 2004).

In children and young people, good mental health can be indicated by being able to:

- develop emotionally, creatively, intellectually and spiritually
- initiate, develop and sustain mutually satisfying personal relationships
- face problems, resolve them and learn from them in ways appropriate for the child's age
- develop a sense of right and wrong
- be confident and assertive
- be aware of others and empathise with them
- enjoy solitude
- play and learn.

(Mental Health Foundation, 2002)

Following the Children's Health Outcomes Forum Report in 2012 in England the DH response included a commitment to: "Improve the mental health of our children and young people by promoting resilience and mental wellbeing and providing early and effective evidence based treatments for those people who need it" (DH, 2013).

Risk and protective factors

Any child can experience mental health problems, but some children and young people are at greater risk of developing mental health problems than others, whereas certain factors can act as protection.

These risks and protective factors can be related to the child's personality, family, socio-economic status and environment.

Children and young people in special circumstances or those with learning difficulties and/or disabilities can be at greater risk. For these children and their parents or carers, the provision of early intervention may make a significant difference (*National Service Framework, DH, 2004*).

Knowledge of the factors that increase the risk of problems developing or being sustained is important when considering how to improve the mental health of children and young people (Townley, 2002).

Child risk factors include:

- poverty
- family breakdown
- single parent family
- parental mental ill health
- parental criminality, alcoholism, or substance abuse
- overt parental conflict
- lack of boundaries
- frequent family moves/being homeless
- over protection
- hostile and rejecting relationships
- failure to adapt to the child's developmental needs
- death and loss, including loss of friendships
- caring for a disabled parent
- school non-attendance.

Family risk factors include:

- learning disability
- abuse
- domestic violence
- prematurity or low birth weight
- difficult temperament
- physical illness
- lack of boundaries
- looked-after children
- lack of attachment to carer
- academic failure
- low self-esteem
- shy, anxious or difficult temperament
- young offenders
- chronic illness.

(Department of Health, 2004a).

External risk factors include:

- school: unclear discipline, failure to recognise children as individuals
- bullying – including cyber bullying
- peer rejection/peer pressure
- school exclusion including school refusal.

Protective factors include:

- a good start in life and positive parenting
- being loved and feeling secure
- living in a stable home environment
- parental employment
- good parental mental health
- activities and interests
- positive peer relationships
- emotional resilience and positive thinking
- sense of humour
- full engagement with education.

Promoting good mental health

“Social and emotional wellbeing creates the foundations for healthy behaviours and educational attainment. It also helps prevent behavioural problems (including substance misuse) and mental health problems. That’s why it is important to focus on the social and emotional wellbeing of children and young people” (NICE, 2013).

All children and young people, their parents or carers, require access to information and supportive environments to ensure that the child or young person’s mental health is promoted.

“Two key skills are necessary for positive mental health – learning to cope and even prosper in the face of adversity and the ability to create feelings of happiness through healthy, positive means... If children and young people have pleasure, engagement and meaning in life, they are likely to experience happiness, life satisfaction, wellbeing and lead more flourishing lives” (Ward, 2008).

Good practice towards achieving this includes:

- the ability of frontline staff to access support and advice from specialist child and adolescent mental health services (CAMHS) and other children’s services to aid the early identification and support of those with mental health difficulties. These include social workers, behaviour specialists, educational psychologists and specialist support staff
- local protocols for referral
- ensuring that local needs’ assessments identify children in special circumstances – including those who are homeless, seeking asylum, misusing substances, living in young offender settings and those ‘looked after’, not attending school – and that services are in place to meet their needs
- an emphasis on children and young people who are vulnerable to mental health problems and on providing focused, structured, proactive programmes which target risk factors, using a common assessment framework as appropriate

- specific activities such as tackling bullying (including cyber bullying) and increasing awareness of mental health issues
- promoting lifestyles that protect children and young people from mental health problems.

“School nurses have an important role in the early assessment and increasingly in delivering effective early interventions for children and young people with mental health problems” (DfES, 2001). Examples of interventions by school nurses are given in this document.

Parents and carers

Parents whose children have never experienced worries, fears, bullying, sadness, problems with friendships and bereavement are in the minority.

Parents whose child has mental health difficulties are often made to feel it is their fault, and as a result they do not tell anyone. It is common for parents and carers to feel isolated and alone in trying to deal with their child’s problems.

In some instances, issues such as family breakdown, poverty and parenting difficulties may have contributed to the child or young person’s problems. However, practitioners should remain non-judgmental in their approach to parents and carers, aiming to support and assist them. Several charities offer specific help to parents and carers and knowledge of these organisations can be useful. See [page 24](#) for a list of useful websites.

What is mental ill health?

It is now common to differentiate between mental health problems and disorders, the former being regarded as less severe (Townley, 2002). However, mental health problems can be distressing to the child and family, resulting in their seeking help from a health care professional.

Problems may include:

- sleeping difficulties
- eating difficulties
- unhappiness
- bed wetting that does not have a physical cause
- faecal soiling without a physical cause
- over-activity
- tantrums, oppositional and defiant behaviour
- psychosomatic symptoms – for example, abdominal pain without a physical cause.

(Kurtz, 1992, cited in Townley, 2002).

Mental health disorders include:

- conduct disorders, for example persistent or extreme defiance, physical and verbal aggression, vandalism
- emotional, for example phobias, anxiety, depression or obsessive compulsive disorder
- neurodevelopmental disorders, for example, attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorders
- eating disorders, for example pre-school eating problems, anorexia nervosa and bulimia nervosa
- substance misuse problems
- post-traumatic stress disorder
- psychosis
- emerging personality disorder
- self-harm and suicidal ideas and actions.

For more information, visit www.chimat.org.uk/camhs

General assessment

Where a practitioner's initial assessment of a child or young person, or their interaction with the parents/carer gives cause for concern, it is important to share information with another professional and to initiate further assessment. In some situations where the child or young person is at immediate risk, involvement of a specialist mental health practitioner may be needed urgently. Local safeguarding policies should clearly identify these situations and all nurses should be aware of these policies.

The common assessment framework (CAF) in England, the integrated assessment framework (IAF) in Scotland and the framework for the assessment of children in need and their families in Wales provide standardised approaches to conducting an assessment of a child's additional needs, before deciding how those needs should be met. For specific mental health problems, other tools may be used to complement these frameworks. These are shown within the section, 'specific problems'.

Here are some situations where a common assessment might be initiated:

- missing developmental milestones or, for example, making slower progress than expected at school, regularly missing medical appointments and immunisations
- presenting challenging or aggressive behaviours – for example, bringing a knife into school, abusing/misusing substances or committing offences
- experiencing physical or mental ill health or disability – either their own or their parents
- exposure to substance abuse/misuse, violence or criminality within the family
- experiencing bereavement or family breakdown
- being bullied or bullying (including cyber bullying)
- being disadvantaged for reasons such as race, gender, sexuality, religious belief or disability
- being homeless, threatened with eviction, or living in temporary accommodation
- becoming a teenage mother/father or being the child of teenage parents
- persistent truanting.

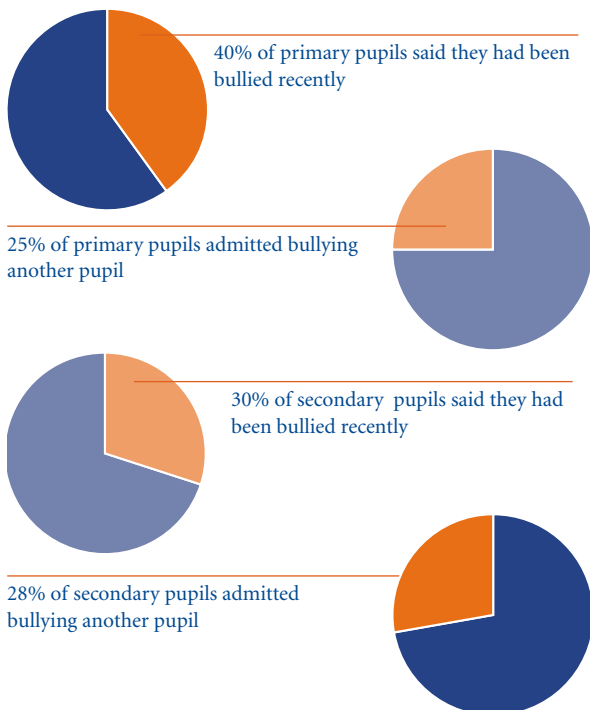
Some core themes

There are some situations that can lead a child or young person to experience mental health problems. This section includes some examples that practitioners may encounter but is not intended to be definitive.

Bullying including digital (cyber) bullying

While bullying is common, it should always be viewed as unacceptable as it can seriously affect a child or young person's mental health. Bullying can be physical or psychological. It can take various forms, such as teasing, name calling, hitting, kicking, telling nasty stories or social exclusion.

In a study of bullying in 120 schools in Northern Ireland, carried out in 2000, 40 per cent of primary pupils said that they had been recently bullied. Meanwhile 25 per cent admitted bullying another pupil.



When secondary pupils were asked, 30 per cent said that they had been recently bullied, with 28 per cent saying they had bullied another pupil (Department of Education Northern Ireland, 2007).

There are some signs and symptoms that can indicate a child or young person is being bullied. These include:

- unexplained scratches and bruises
- crying themselves to sleep
- nightmares
- depression
- self-harm
- headaches
- abdominal pain
- fear of walking to or from school
- school refusal or truancy
- poor school performance
- change in behaviour, for example social isolation.

It is important for practitioners to be aware of these signs and to ask a child directly, either alone or with their parents, whether they have been bullied.

Questions you can ask:

- Have you been bullied?
- Has anyone at school been horrible to you?

Be suspicious, even if the child says no (Spender et al., 2001).

Although the school should deal with the bullying, the child or young person's emotional or behavioural symptoms may mean referral to a mental health specialist is needed.

Abuse

Child abuse falls into four categories: physical, sexual, emotional and neglect. Children who have been abused can experience difficulties for many years. The behavioural effects of abuse may include:

- problems at school
- prostitution/sexual exploitation
- teenage pregnancy
- suicide attempts/self-harm
- alcohol and drug abuse
- eating disorders.

Children and young people with learning disabilities or those who are 'looked after' are particularly vulnerable to abuse. Where abuse has not been previously disclosed it is important to follow local safeguarding policies.

Practitioners have an absolute duty to share any concerns they may have that concern possible abuse. Remember that referral is an obligation, not an option.

Long-term conditions

Children with long-term conditions are twice as likely to suffer from emotional problems or disturbed behaviour. This is especially true of physical illnesses that involve the brain, such as epilepsy and cerebral palsy (Royal College of Psychiatrists, 2004a).

Children with long-term conditions may show various emotional problems, such as rebellion or withdrawal from social settings. Other problems may include non-adherence to treatment, under-achievement in school and regressive behaviours such as bed-wetting and temper tantrums (Taylor, 1999).

As mental health problems may be overshadowed by the child or young person's chronic health problem, they can be overlooked (Vessey, 1999). Using a common assessment framework can help practitioners to identify problems.

Restrictive physical intervention and therapeutic holding

It may be necessary to restrain a child or young person in order to prevent significant or greater harm to the child, practitioners or others. For example, this may happen when de-escalation techniques have been unsuccessful for a young person under the influence of drugs or alcohol.

“If restrictive physical interventions are required the degree of force should be confined to that necessary to hold the child or young person whilst minimising injury to all involved” (RCN, 2010).

It is important for employers to ensure there are procedures and policies for assessing the risk of violent behaviour. Practitioners should be given appropriate essential training.

Specific mental health disorders

The list below is not intended to be definitive and reference to other disorders, causes, help treatment, additional references and case studies can be found at: www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo.aspx

Anxiety

Anxiety disorders are the most common mental health problem affecting children and young people. It is estimated that 10 per cent of young people experience this problem. Many children have times when they feel frightened about things and it is a normal part of growing up. Teenagers may be moody and worried about how they look, what other people think of them, and how they get on with people in general, particularly the opposite sex (Royal College of Psychiatrists, 2004b). Although there are many possible causes of anxiety, practitioners should be aware of links with street drugs, such as amphetamines, LSD or ecstasy.

Anxiety is a sense of worry, apprehension, fear and distress. Symptoms can be both physical – for example, a headache or nausea – and emotional – feeling nervous or afraid. The child or young person's thinking, decision making, learning and concentration can be adversely affected. In addition, anxiety can lead to physiological changes, such as a raised blood pressure and heart rate, vomiting, pain and diarrhoea.

Persistent and intense anxiety that is disruptive to everyday life requires attention (Rethink, 2007). Nurses working with children and young people, particularly school nurses, can help by facilitating the child or young person to talk about the cause of their anxiety, teaching relaxation techniques and giving information on further support. It may be necessary to seek a medical assessment.

Depression

It is estimated that one in every 200 children under 12 years old and two or three in every 100 teenagers experience depression. However, they are often unwilling to seek help because of the stigma associated with mental health problems (NICE, 2005a). Signs and symptoms of depression can include:

- being moody and irritable – easily upset, ‘ratty’ or tearful
- becoming withdrawn – avoiding friends, family and regular activities
- feeling guilty or bad, being self-critical and self-blaming
- feeling unhappy, miserable and lonely a lot of the time
- feeling hopeless and wanting to die
- finding it difficult to concentrate
- not looking after their personal appearance
- changes in sleep pattern: sleeping too little or too much
- tiredness and lack of energy
- changes in appetite
- frequent minor health problems, such as headaches or stomach pains.

Some young people may express or escape from their negative feelings and thoughts through acting recklessly – for example, taking drugs, drinking too much, risky sexual behaviour or getting into dangerous situations. Others who are very depressed can become preoccupied with thoughts of death and may attempt suicide or harm themselves.

Many children and young people can be helped by someone who is willing to listen to their anxieties, such as a family member. In addition, telephone help lines, such as Childline and the Samaritans, are useful.

Clear guidance on managing depression is given in the National Institute for Health and Care Excellence (NICE) document, *Depression in children and young people* (NICE, 2005a). Practitioners working in universal services can care for children and young people with mild depression where the following circumstances apply:

- exposure to a single undesirable event, in the absence of other risk factors for depression
- exposure to a recent undesirable life event in the presence of two or more other risk factors, with no evidence of depression and/or self-harm

- exposure to a recent undesirable life event where one or more family members – parents or children – have multiple-risk histories for depression, providing that there is no evidence of depression and/or self-harm in the child/young person
- mild depression, without co-morbidity.

Health care professionals in primary care, schools and other relevant community settings should be trained to detect symptoms of depression and to assess children and young people who may be at risk. Training should include:

- the evaluation of recent and past psychosocial risk factors, such as age, gender, family discord, bullying, and physical, sexual or emotional abuse
- co-morbidity disorders, including drug and alcohol use, and a history of parental depression
- the natural history of single loss events
- the importance of multiple risk factors
- ethnic and cultural issues
- factors known to be associated with a high risk of depression, including problems such as homelessness, being a refugee or living in an institutional setting (NICE, 2005a).

Self-harm

Self-harm is more common among teenage girls. However, boys who self-harm must be taken seriously, given an increased risk of suicide. According to the National Children’s Bureau, self-harm usually involves cutting, but can include taking an overdose of tablets, scratching or burning. Self-cutting can become habit forming and is often kept secret. Attempted hanging is rare, but clearly very serious.

Many people who self-harm take care to hide any damage or scars. Acts of self-harm can be impulsive and secretive and denial is common. Consequently, it can be difficult for health care professionals to identify those who are at risk. Best practice is that all children and adolescents who have harmed themselves should be admitted to hospital (Spender et al., 2001). NICE advises that in accident and emergency departments:

- triage, assessment and treatment should be undertaken by children’s nurses and doctors trained to work with children and young people who self-harm. It should take place in a separate area of the emergency department for children and young people

- all children and young people should normally be admitted into a children's ward under the overall care of a paediatrician, and be assessed fully the following day
- those who are involved in the emergency treatment of self-harm by children and young people should be adequately trained to assess mental capacity in children of different ages, understanding how issues of capacity and consent apply to this group. They should have access at all times to specialist advice. In addition, they should understand confidentiality, consent, parental consent, child protection issues, and the use of the Mental Health and Children Acts.

The single most important thing a professional can do after a young person's overdose is to encourage communication between the young person and important others (Spender et al., 2001). Screening instruments can also be useful. The PATHOS questionnaire provides several key questions:

- have you had problems for longer than one month?
- were you alone in the house when you overdosed?
- did you plan the overdose for more than three hours?
- are you feeling hopeless about the future – that things will not get much better?
- were you feeling sad for most of the time before the overdose?

This score is then mapped onto a risk assessment scale.

Practitioners should always treat people who self-harm with care and respect (NICE, 2004b).

Good practice for coping with those who self-harm

Negative attitudes and reactions can have a critical influence on whether young people will seek support. See the *National inquiry into self-harm*: www.mentalhealth.org.uk/content/assets/PDF/publications/truth_hurts.pdf

- Ensure adequate training in self-harm, consent, confidentiality and child protection.
- Encourage the young person to talk to important others.
- Use a screening tool – for example, the PATHOS scale.
 - If an emergency, admit children and young people to hospital.
- Advise parents to remove all means of self-harm before the child goes home.

(Spender et al, 2001).

Advise parents/carers to be vigilant when a young person returns home as it may not be possible to remove all means of self-harm as young people can be very creative finding tools.

A handbook and e-learning package for self-harm in children and young people can be found at:

www.chimat.org.uk/resource/view.aspx?RID=105602

It provides basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children's services can respond.

Substance misuse

NICE guidance (NICE, 2007) defines substance misuse as: "Intoxication by, or regular excessive consumption of and/or dependence on psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances)."

Many young people experiment with illegal substances such as cannabis or ecstasy at some stage, but only a small number are regular users (Spender et al., 2001). Other substances used include other hallucinogens, amphetamines, opiates (heroin and cocaine), and prescription only medicines, such as anti-depressants.

In most instances the young person will not seek help for an addiction, but will present with other problems. This may include difficulties at school, signs of depression, inappropriate sexual behaviour or because a parent has become worried.

Some clues may indicate excessive drug use:

- changes in attitude or behaviour – for example, lying or stealing
- mood changes
- deterioration in physical health
- sexually transmitted infections.

(Spender et al., 2001).

It is likely that the young person may not see that they have a problem and seldom want to do anything about their

substance misuse. It may be the parents who are expressing concern. In the first instance, harm minimisation to reduce the risks may be the best course of action. This involves giving information to the young person and their family, by providing leaflets, websites and telephone numbers.

Referral to a drug counselling service may be difficult. It will need the young person to be motivated. Services are scarce in some areas.

Vulnerable and disadvantaged children and young people are particularly at risk of substance misuse. Influencing factors may include:

- family members who misuse substances
- behavioural, mental and social problems
- exclusion from school or truancy
- young offenders
- looked-after children
- homelessness
- commercial sex workers
- black and minority ethnic backgrounds.

For these children and young people, NICE recommends the use of screening tools to identify vulnerable and disadvantaged children and young people under 25 who may be at risk of substance abuse. For those at risk, referral to professionals with specialist expertise in delivering community based interventions is recommended.

Screening tools include:

- common assessment frameworks
- substance abuse subtle screening inventory – adolescent version (SASSI Institute).

What you can do:

As a universal practitioner working with children and young people who may be misusing substances, you should be able to provide:

- accurate and age appropriate drug and alcohol information, advice and education
- support, advice and information for parents and carers
- a referral to another service.

(Britton and Noor, 2003).

Conduct disorders

“Behavioural disorders such as conduct disorder and oppositional defiant disorder entail more than a child being occasionally naughty, difficult, stubborn or aggressive; the child has to present with a persistent, repetitive pattern of not sticking to the rules or disobeying socially accepted norms” (Ryan and Prymachuk, 2011). In oppositional defiant disorder (ODD) the child or young person has persistently hostile behaviour that is not aggressive or anti-social. Behaviour problems are common complaints and they may be difficult to address.

There are a number of risk factors that can lead to antisocial behaviour. These include:

- attention deficit hyperactivity disorder
- specific learning difficulties – for example, reading or language delay
- poor child-rearing practices
- parent-child interactions that contribute to the persistence of the behaviours
- any form of child abuse
- losses that the child views as important
- school and social influences.

What parents may say:

- “He’s on the go all the time.”
- “He won’t do as he’s told.”
- “He answers back.”
- “He hits other children.”

(From Spender et al, 2001)

Specific issues in young children include tantrums, aggression and sibling rivalry.

NICE guidance recommends that conduct disorders need to be assessed by a psychiatrist, clinical psychologist or other professional with the necessary competence in the area of children and young people’s mental health.

Where problems start at an early age, the long-term outcome is usually poor, unless the child gets early and effective treatment. There can be a detrimental impact on the whole family.

Management for conduct disorders can include behavioural, cognitive and psychosocial skills training, play, music and

art therapy. Parent training and education programmes are also beneficial. NICE recommends the development of group-based programmes with individual programmes as necessary. These programmes are structured and based on principles of social learning theory.

Parent training/education programmes should be eight to 12 sessions and delivered by trained and skilled facilitators, with supervision (NICE, 2006).

Eating disorders

Eating disorders can manifest themselves in a variety of ways. The most serious are anorexia and bulimia nervosa. Obesity is also an eating disorder but this is not usually regarded as a specific mental health problem.

Anorexia nervosa is determined food avoidance resulting in weight loss, or failure to maintain a steady weight gain related to increasing age. The child or young person is preoccupied with their weight and shape and has a distorted body image. While it has traditionally been seen as affecting mostly teenage girls, the incidence in younger children and boys is increasing.

The young person experiencing bulimia nervosa will have recurrent food binges followed by compensatory behaviour, such as vomiting, laxative use, excessive exercise and fasting.

Eating disorders can cause severe physical and psychiatric problems and occasionally death. Intervention in the early stages of the illness is more likely to be successful.

A person with an eating disorder usually keeps their behaviour secret and may deny the problem if confronted. While eventually someone notices or the person realises they need help, this can take months or even years.

The 'scoff' questions can be helpful for identifying possible cases of eating disorder.

- Do you make yourself sick because you feel uncomfortably full?
- Do you worry you have lost control over how much you eat?

- Have you recently lost more than one stone in a three month period?
- Do you believe yourself to be fat when others say you are too thin?
- Would you say that food dominates your life?

Score one point for every 'yes'. A score of two or more points indicates a likely case of eating disorder.

Children and young people with an eating disorder will need specialist care and should be referred to a child and adolescent mental health service as soon as possible. Continuing care may be within a children's setting, where close links with specialists will be needed. Practitioners should acknowledge that many people with eating disorders are ambivalent about treatment. They should also recognise the consequent demands and challenges this presents.

It is important for patients and, where appropriate, carers to be provided with education and information on the nature, course and treatment of eating disorders.

Psychosis

What is psychosis?

Young people often worry that they may be 'going mad' when they are feeling stressed, confused or very upset. In fact, worries like this are rarely a sign of mental illness. 'Psychosis' is when your thoughts are so disturbed that you lose touch with reality. This type of problem can be severe and distressing.

How common is it?

Psychosis affects people of all ages, but is rare before you reach the older teenage years.

What causes psychosis?

When you have a psychotic episode, it can be a signal of another underlying illness. You can have a psychotic episode after a stressful event like losing a close friend or relative. It can also be the result of:

- a physical illness (like a severe infection)
- the use of illegal drugs (like cannabis)
- a severe mental illness (like schizophrenia or bipolar disorder).

Sometimes it is difficult to know what caused the illness. See the Royal College of Psychiatry website for information for parents and young people: www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/youngpeople/psychosis.aspx

When to involve a specialist

Local policies should give clear guidance to practitioners regarding referral and the support available to them.

Supporting children and young people with mental health problems is not the responsibility of specialist services alone (*Every Child Matters*, DfES, 2004a). However, the term child and adolescent mental health service (CAMHS) is sometimes used narrowly to refer only to specialist child and adolescent mental health services. There are local variations in the services provided and differences in referral procedures. The roles of the different CAMHS tiers in England are shown below. References for the other UK countries are given on [page 27](#).

Tier 1

Services provided by practitioners in universal services (such as GPs, health visitors, school nurses, teachers and youth workers) who are non-specialists who can:

- offer general advice and in certain cases, treatment for less severe problems, promote mental health, aid early identification of problems and refer to specialist services.

Tier 2

A service provided by specialist individuals who offer:

- training and consultation for other professionals
- consultation for families and carers
- outreach to families and children requiring more help, who are unwilling to use specialist services
- assessment, which may trigger further treatment.

Tier 3

A specialist multi-disciplinary service for more severe, complex, or persistent disorders, offering:

- assessment and treatment
- assessment for referrals to tier 4
- contributions to consultation and training at tiers 1 and 2
- participation in research and development projects.

Tier 4

Tertiary services such as:

- day units
- highly specialised out-patient out patient teams and in-patient units.

Issues for practice

Child and young person focus

Some core elements of practice can assist in promoting the wellbeing of children and young people. It is important that practitioners base their practice on the needs of children and young people and seek ways to ensure those needs are identified. Young people have described some of the barriers to their effective use of services:

- services are not well known, accessible, responsive or child centred
- particular issues of access to services due to disability, poverty, ethnicity, being in care (looked after) and sexual orientation.

Communicating

Successful interaction is important for learning the child or young person's story and for ensuring appropriate care and management. Cooper and Gasper (2001) suggest that when working with and assessing young people, nurses need to find a way of interacting that is more than 'having a chat' but is not doing therapy. To do this, nurses must be aware of how they are influenced by their personal belief system and that of the environment. Similarly, they should be aware of cultural issues that may influence their care and judgements.

Active listening involves:

- observing and reading non-verbal behaviour – for example, posture, facial expressions, movement or tone of voice
- listening and understanding verbal messages
- listening to the whole person, in the context of the social settings of life
- tough-minded listening – accepting that a client's feelings and visions of themselves are valid.

Obstacles to adequate listening include:

- being distracted
- judging the merits of what's being said, using our own value system

- filtering the information
- using professional knowledge to filter information
- fact-centred listening, rather than person-centred.

(Egan 1990, cited in Glasper and Richardson, 2006).

In Wales, attention must be given to the Welsh Language Act (1993) whereby individuals can choose to communicate in their language of choice. Local procedures will advise practitioners on actions that facilitate this.

Where the first language of children, young people and their parents/carers is not English, it is important to ensure their understanding, providing interpreting services and/or written material in an appropriate language.

Confidentiality

The United Nations Convention on the Rights of the Child, Article 12 enshrines the principle of self-determination. Nurses should treat any information in confidence, unless the young person consents to it being disclosed. However, the nurse also needs to consider the interests of the young person and where there is significant risk; the information will need to be disclosed. Examples of such situations include:

- abuse
- if the young person is likely to harm themselves, or others are at risk from harm
- if the young person may be involved in serious criminal activity.

Confidentiality should not be a barrier to effective communication with families and carers. Often, carers can be given information in general terms, without breaching confidentiality. Similarly, the concerns of carers can be heard whilst maintaining the privacy of the child. Where confidentiality is an issue, every effort should be made to negotiate with the young person about what information can and cannot be shared. If a decision is made to share information, the young person should be told.

Consent

“The same principles which are used when seeking consent for the treatment of children’s physical disorders apply when children are suffering from a mental disorder. Once children reach the age of 18, no-one else can take decisions on their behalf” (DH, 2001).

If the person is under the age of 16 (a minor), nurses and midwives must be aware of local protocols and legislation that affect their care or treatment. Consent of people under 16 is very complex, local, legal or professional organisation advice may need to be sought. Children under the age of 16 are generally considered to lack the capacity to consent or to refuse treatment. The right to do so remains with the parents or those with parental responsibility unless the child is considered to have significant understanding and intelligence to make up his or her own mind about it. Children of 16 or 17 are presumed to be able to consent for themselves although it is good practice to involve the parents. Parents or those with parental responsibility may override the refusal of a child of any age up to 18 years. In exceptional circumstances, it may be necessary to seek an order from the court. www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics/consent/

In Scotland, the age of legal capacity is 16 years and is regulated by the Age of Legal Capacity (Scotland) Act, 1991. This Act sets out the current position on the legal capacity of children, including giving or withholding consent to treatment. The law is broadly similar to that in England and Wales; however one important difference is that parental consent cannot override a refusal of consent by a competent child.

Wherever possible, a child or young person should receive treatment for their mental health problem on a consensual basis. This should be either the child’s own consent – where the child is deemed competent to give it – or with consent from a person with parental responsibility and the co-operation of the child – where the child lacks capacity in relation to the decision in question. A trusting relationship with the child can help to achieve this. It is important to take the child’s view into account, even when you may disagree with them (Article 24, UN Convention on the Rights of the Child).

Legislation

The Nursing and Midwifery Council's (NMC) Code (2008) states: "You must be aware of the legislation regarding mental capacity, ensuring that people who lack capacity remain at the centre of decision-making and are fully safeguarded."

"Not only must young people under 18 suffer with a disorder they usually know little about, but also their parents must know about it for them to receive any professional treatment. If the parent and child have a poor relationship, the experience can be even harder for the child and in some cases treatment may be refused in order to keep the illness from their parents" (YoungMinds, 2005).

In England and Wales, relevant legislation includes:

- **The Children Act 1989** – this allows for court involvement in individual treatment decisions and tends to be perceived as less stigmatising than the Mental Health Act 1983, but it does not specifically address mental disorder.
- **The Mental Health Act, 1983, amended by the Mental Health Act, 2007** – this has no lower age limit and there are no specific provisions in the Act relating to children. In theory, children and young people may be treated or compulsorily detained under it, but in practice very young children are not detained under the Act, with the majority being admitted as 'informal' patients by their parents.
- **The Mental Health Act 2007** requires hospital managers to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is age appropriate.
- **The Mental Capacity Act 2005** – this does not generally apply to children under 16. Its principles apply to decisions related to the care and treatment of young people who lack mental capacity to consent, including treatment for mental disorder.

Legislation in Scotland includes:

- **Children (Scotland) Act 1995** – this safeguards children and young people.
- **Mental Health (Care and Treatment) (Scotland) Act 2003** – this places a responsibility on health boards to provide for children and young people under the age of 18, who are detained under the Act, or admitted to hospital for treatment services accommodation 'sufficient to meet the particular needs'.
- **The Adults with Incapacity (Scotland) Act 2000** Part 5, Medical Treatment and Research.
- **The Mental Health (Care and Treatment) (Scotland) Act 2003** – these both provide for delivering health care to people who lack the ability to make treatment decisions for themselves.
- **The Age of Legal Capacity (Scotland) Act 1991** – this outlines that someone has the capacity to make decisions about consent from the age of 16. However, even under the age of 16, a young person may have the legal capacity to make a consent decision on a health care intervention, provided that they are capable of understanding its nature and possible consequences.

Legislation in Northern Ireland includes:

- **The Mental Health (Northern Ireland) Order 1986** currently provides the framework for mental health issues. There is no legislation pertaining to mental capacity.
- **The Bamford Review of Mental Health and Learning Disability (Northern Ireland)** recommended the introduction of a comprehensive legislative framework to include capacity issues and the needs of children and young people; this legislation is being developed.

Culture

Concepts of mental illness and the understanding of the origins of children's emotional and behavioural difficulties vary across cultures. Nurses need to be sensitive to these differences and ensure they are equipped with the knowledge to work effectively with different groups represented within the community they serve.

Positive steps – supporting race equality in mental healthcare (DH, England, 2007) gives the following advice:

- be prepared to develop friendships with everyone. Be politically astute and politically balanced. Don't get caught up in race politics. If your own ethnicity differs from that of a client or community member, never feel you have to apologise for that difference
- never feel you have to justify who you are. Saying things like, 'I'm not a racist, some of my best friends are black,' will only undermine your position
- a white mental health staff worker is no less equipped to provide a culturally responsive service for black and minority ethnic (BME) clients than a black or Asian staff worker. Competency and commitment will cross all ethnic boundaries
- be prepared to stop, reflect and even start again if necessary. Keep the bigger picture in mind; a few setbacks and defeats don't mean you won't succeed in the long term.

Summary

The mental health of the child or young person influences the adult they will grow up to be. Three quarters of adult mental health disorders are evident before the age of 21 years. Effective, early intervention can be essential in preventing the development of ill health and disability. (www.rcpch.ac.uk/minded). By gaining knowledge on issues concerning the mental health of children and young people, practitioners can develop the skills needed for providing effective care and support. In addition, by being well-informed, practitioners can act in their professional and personal lives to break down the stigma that is so frequently associated with mental health problems.

We hope that this document will assist practitioners in achieving these goals.

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Useful websites

Action for Children

Support of vulnerable children, young people and families.
www.actionforchildren.org.uk

ADDISS (National Attention Deficit Disorder Information and Support Service)

Providing people-friendly information and resources about attention deficit hyperactivity disorder to anyone who needs assistance.
www.addiss.co.uk

Alcoholics Anonymous

For help with drinking problems.
www.alcoholics-anonymous.org.uk
 Great Britain National Helpline 0845 769 7555

Beat

Understanding eating disorders, focusing on anorexia and bulimia nervosa and how you can help.
www.b-eat.co.uk

Beat Bullying

All about young people helping and supporting each other online, explains cyber bullying.
www.beatbullying.org

BMENTAL Health

Umbrella charity for issues concerning mental health in black and minority ethnic communities.
www.bmehealth.org.uk

Bullying UK

Find advice on all aspect of bullying including cyber bullying. Help and advice for victims of bullying, parents and schools.
www.bullying.co.uk

CEOP (Child Exploitation and Online Protection)

Child exploitation and online protection centre
www.ceop.police.uk

Children's Commissioner for Wales

Standing up for children and young people's rights.
www.childcom.org.uk

Childline

Providing a free and confidential telephone service for children.
www.childline.org.uk
 Helpline: 0800 1111

Childnet International

International non-profit organisation working with others to help make the internet a great and safe place for children.
www.childnet.com

Children's Commissioner for England

Championing children and young people in England.
www.childrenscommissioner.gov.uk

Children's Commissioner for Northern Ireland

Promoting the rights of children and young people.
www.niccy.org

The Children's Society

Works with children and young people who are struggling to cope with the pressures of everyday life.
www.childrenssociety.org.uk

Children in Scotland

National agency for voluntary, statutory and professional organisations and individuals working with children and their families in Scotland.
www.childreninScotland.org.uk

Children in Wales

National umbrella organisation for those working with children and young people in Wales.
www.childreninwales.org.uk

Contact a Family

Advice and support for families with disabled children.
www.cafamily.org.uk

Department for Education in England

Responsible for education and children's services in England.
www.education.gov.uk

Department of Education, Northern Ireland

Responsible for education and children's services in Northern Ireland.
www.deni.gov.uk

Depression Alliance

Working to relieve and prevent this treatable condition by providing information and support services.
www.depressionalliance.org

Family Action

Providing a range of services for families with complex needs.
www.family-action.org.uk

Family Lives

National support charity in all aspects of family life.
www.familylives.org.uk

Funky Dragon

Children and young people's assembly for Wales – a peer led organisation.
www.funkydragon.org

Health Behaviour in School-aged Children (HBSC)

A World Health Organization collaborative cross-national study.
www.hbsc.org

Health Rights Information Scotland

Helping you find clear, accurate and up-to-date information about your health rights.
www.hris.org.uk

The Incredible Years

Preventing and treating young children's behaviour problems and promoting their social, emotional and academic competence.
www.incredibleyears.com

Kidscape

Provides advice, training courses and helpful booklets and information about bullying. Anti-bullying helpline for parents: 08451 205 204
www.kidscape.org.uk

legislation.gov.co.uk

Revised enacted UK legislation.
www.legislation.gov.uk

Mental Health Foundation

A UK mental health research, policy and service improvement charity.
www.mentalhealth.org.uk

Mental Welfare Commission for Scotland

Ensuring that care, treatment and support are lawful and respecting the rights and promoting the welfare of individuals with mental illness, learning disability and related conditions.
www.mwscot.org.uk

Mind

Mental health charity providing information, advice and training.
www.mind.org.uk

MindEd (portal of Royal College of Paediatrics and Child Health)

The MindEd website will provide free e-learning to help adults to identify and understand children and young people with mental health issues.
www.rcpch.ac.uk/minded

National Treatment Agency for Substance Misuse (now part of Public Health England)

Promoting a balanced and ambitious treatment system and supporting local commissioners by providing high quality information and intelligence about drugs and alcohol.
www.nta.nhs.uk

NHS Health Scotland

Scotland's Health Improvement Agency.
www.healthscotland.com

Northern Ireland Association of Mental Health

The largest and longest established independent charity focusing on mental health and wellbeing services in Northern Ireland.
www.niamh.co.uk

Public Health Agency in Northern Ireland

The major regional organisation for health protection and health and social wellbeing improvement in Northern Ireland.
www.publichealth.hscni.net

Royal College of Psychiatrists

Includes parents and youth information index and case studies, further information and references.
www.rcpsych.ac.uk

Research in Practice

Supporting evidence-informed practice with children and families.

www.rip.org.uk

Respect Me

Scotland's anti-bullying service.

www.respectme.org.uk

The Samaritans

A charity offering confidential, non-judgemental support, 24 hours a day.

www.samaritans.org

Scotland's Commissioner for Children and Young People

This site is for children and young people in Scotland, your parents and the adults who work with them.

www.sccyp.org.uk

Scottish Association for Mental Health

www.samh.org.uk

The Scottish Government

The responsibilities of the Scottish Government include health, education, justice, rural affairs, housing and transport.

www.scotland.gov.uk

Scottish Government Health and Social Care

Directorates

Aiming to help people sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care.

www.sehd.scot.nhs.uk

Scottish Intercollegiate Guidelines Network (SIGN)

SIGN develops evidence-based clinical practice guidelines for the NHS in Scotland. SIGN guidelines are derived from a systematic review of the scientific literature and are designed as a vehicle for accelerating the translation of new knowledge into action to meet our aim of reducing variations in practice, and improving patient-important outcomes.

www.sign.ac.uk

The Sector Skills Council for Health

Skills for Health in your Sector Skills Council, for all health employers; NHS; independent and third sector. Everything we do is driven by your skills and workforce needs.

www.skillsforhealth.org.uk

Self-Harm: Recovery, Advice and Support

Support for young people impacted by self-harm.

<http://selfharm.co.uk/home>

TheSite.org

Your guide to the real world.

www.thesite.org/healthandwellbeing/mentalhealth

Triple P (Positive Parenting Program)

One of the most effective evidence-based parenting programs in the world, backed up by more than 30 years of ongoing research.

www.triplep.net

Young Minds

Committed to improving the emotional wellbeing and mental health of children and young people.

www.youngminds.org.uk

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September 2014

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Published by the Royal College of Nursing
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London
W1G 0RN

020 7409 3333

Publication code: 003 311

ISBN: 978-1-910066-30-0