

Practice and policy reviews

Emotional and behavioural problems in children: the benefits of training professionals in primary care to identify relationships at risk

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ABSTRACT

The number of children with emotional and behavioural problems is escalating. Demand for child and adolescent mental health services exceeds the capacity of the service to meet the need. Government policy, in the guise of the *Priorities and Planning Framework 2003–2006*, the *National Service Framework for Children* and the Green Paper *Every Child Matters*, recognises that a comprehensive collaborative approach is required, which includes training professionals in primary care to identify parent–child relationships at risk, as well as enabling them to offer appropriate support to prevent minor difficulties becoming major problems. This paper begins to explore how professionals in primary care can develop their assessment skills and access appropriate training to enable them to identify and help parents of children with emotional and behavioural problems.

Keywords: behavioural problems, children, emotional problems, training

The problem

The prevalence of emotional and behavioural problems in children is escalating and increasing numbers of longitudinal studies highlight the broad range of adverse sequelae consequent on their occurrence. Concern is rising regarding both the inability of current child and adolescent mental health services to meet demand and the financial and social costs of mental ill health to the nation.^{1–6}

Furthermore, research efforts to elucidate the underlying causes of mental health problems in children suggest that preventive efforts should be focused on providing environments and support that foster sensitive and responsive parenting during the first three years of life.^{4,7}

The policy context

The 'woeful' inadequacy of child and adolescent mental health services (CAMHS) to respond to demand was first highlighted in a report in 1994.⁸ Despite a government advisory document giving guidance on the commissioning, role and management of CAMHS the following year, subsequent reports continued to confirm the inadequate and differential provision of services.⁹⁻¹¹

The Health Advisory Service report (1995) introduced the concept of a four-tier system of child and adolescent mental health services to support an organised, co-ordinated, graded response to child mental health problems.⁹ Tier 1 embraces the whole range of front-line services with whom the public makes direct contact including general practitioners (GPs), health visitors, school nurses, voluntary agencies, teachers, residential social workers and youth justice workers. Tier 2 professionals have a range of specialist skills with respect to the management of children with emotional and behavioural problems and include child psychologists, paediatricians, educational psychologists, child psychiatrists and child community psychiatric nurses/nurse specialists. Tier 2 professionals offer consultancy and training to tier 1, assist in assessing levels of need and facilitate referral on to tier 3 for more in-depth multidisciplinary assessment, if required. Tier 3 services are for children with more complex, severe and persistent disorders and are usually provided by multidisciplinary teams working in child and family consultation services or as part of child psychiatry outpatient provision. Tier 4 refers to inpatient provision.

As the demand for tier 3 services has continued to increase without a commensurate increase in tier 3 staffing levels, waiting lists for specialist assessment and intervention have lengthened and referral criteria have become more exclusive, leaving professionals in primary care to manage increasingly complex emotional and behavioural problems in children, without any additional training or manpower. On the other hand, primary care professionals look for alternative referral pathways and a significant burden of management falls on paediatricians and support services in schools.

In recognition of this deteriorating state of affairs, since February 1999, the government has committed itself to successive increases in annual expenditure on CAMHS, with the goal of providing a comprehensive CAMHS by 2006.¹² It is envisaged that the comprehensive service will embrace a balance of service provision so that all levels of need can be met. This will mean that primary care professionals will need to have sufficient knowledge to enable them to identify children and adolescents 'who need help; offer advice and support to those with

mild or minor problems; and have sufficient knowledge of specialist services to be able to refer on appropriately when necessary.¹³ With the help of additional manpower in the form of primary mental health workers, it is anticipated that professionals in primary care:

- ‘will be able to contribute to the prevention of more serious mental health problems in adolescence and adulthood
- will enable families to function in a manner that is sensitive and responsive to both positive and negative behavioural cues so that they can address any difficulties that may arise at the earliest possible opportunity
- will work collaboratively with parents, children and young people to seek and implement appropriate, acceptable and effective interventions and support.’⁹

The recently published Green Paper *Every Child Matters* lends further justification to the need to train primary care professionals to be able to identify vulnerable children, unhelpful parenting practices and relationships at risk, in order to take ameliorative action at the earliest possible opportunity, not just to prevent emotional and behavioural problems in children, but also to protect those children who are at risk of significant harm or neglect.¹⁴ Various training programmes have therefore been developed across the country to increase the capacity in primary care to identify, manage and prevent emotional and behavioural problems in children.¹⁵

Early signs and causes of emotional and behavioural problems in children

Although we have known from the 1950s that the quality of the emotional relationship between a parent and child determines that child’s pattern of attachment and sense of security, it is only the development of sophisticated neuroimaging techniques in the last decade or so, that has allowed the elaboration of the scientific rationale that underpins attachment theory.^{16–19} It is now generally agreed that the structure and function of the developing brain is determined not only by a child’s genetically determined potential but also by the quality of the nurturing environment that the infant enjoys during the first three years of life.^{17–22}

Neural pathways are activated and reinforced as a consequence of experience and those pathways which are not activated or reinforced are redundant and are eventually ‘pruned’ away. In other words, stimulation from the baby’s world actually generates the building of the corresponding systems to process that stimulation in the baby’s brain.^{17–24} Through the receiving and processing of signals from the outside world, the infant learns to interpret, interact with, and make sense of the world he inhabits. From an evolutionary point of view, this means that every infant learns to adapt to the unique circumstances in which he is raised, so that although the developmental trajectory of every infant is the same, the rate at which the child develops, and the extent to which their developmental

potential is realised, depends on the characteristics of their primary caregiver and the quality of the emotional relationship the infant enjoys with that person.

As the child grows, he becomes less dependent on the primary caregiver, begins to develop social and emotional relationships with significant others and, under favourable circumstances, as he moves towards independence, he develops the capacities for rational thinking, sensitivity, trust and empathy. An important task for the developing infant to master is the capacity for self-regulation. If the infant does not have access to a sensitive and responsive caregiver in the early months and years of life, the infant may first of all have difficulty in learning to regulate his physiological states, may subsequently have difficulty in learning to regulate his degree of arousal in response to stress and ultimately have difficulty in regulating his impulses, his attention and his emotions.^{21–24}

A child who is easily aroused, has difficulty controlling his impulses, focusing his attention or managing his strong emotions is likely to have behavioural problems, although access to a sensitive, responsive caregiver at any stage of his development will help to reduce the likelihood of severe and lasting emotional or behavioural consequences. Conversely, if the child does not have access to a sensitive, responsive caregiver who can offer consistency, predictability, security and affection, early feeding and sleeping difficulties may be the precursors of progressively more difficult and unmanageable behaviours which in turn further exacerbate an often already fragile or misattuned parent–child relationship. Either the parent or the child may react to the lack of reciprocity and understanding with desperation, frustration, anger, aggression, helplessness, disinterest or withdrawal. As a result the child may receive harsh, inconsistent parenting or permissive parenting with no specific expectations or limits and the child may react with demanding, disruptive or attention-seeking behaviour.

Policy into practice: how professionals in primary care can help

Professionals in primary care have a key role to play in identifying and supporting parents who are experiencing difficulties managing their children as they are the professionals who have the unique opportunity to develop long-term relationships with families and are therefore able to observe how parent–child relationships develop over time. It has been demonstrated that professionals can be trained to identify parent–child relationships at risk, in order to offer preventive interventions before emotional and behavioural problems have had the chance to develop.^{25,26}

Just as Bowlby suggested that what infants need from their primary caregivers is time and attention, so it is that parents need time and attention from the clinician. While questionnaires and assessment schedules can help to frame the problem, the key skills the clinician brings to the encounter are active listening, insightful observation and sensitive, respectful enquiry.

The emotions that parents experience in relation to behavioural problems in their child can be very powerful and their very intensity seems to preclude rational thought, sabotaging their ability to present a coherent, logical, sequential picture to the clinician. It is the clinician's job to help the parents make sense of their experiences and ideas. This can be done using a listening technique described by Dilys Daws as 'free floating attention': parents describe the problem in their own way so that the clinician can get a sense of the emotion that goes with the problem, as well as a sense of the parent's 'perception of the origin of the problem and solutions that have been tried and failed'.²⁷ Clinicians also need to bear in mind that parents may have different modes of expression and different beliefs, values, perceptions and expectations that influence the language they use to tell their story and their ability to express themselves in a meaningful way to the clinician.²⁸ Structured questioning and reflective listening can be used to clarify the specific details of the problem. This in itself serves a therapeutic purpose as the clinician is acknowledging the universal 'deep human need to be known about and understood'.^{27,28} Understanding the parent's communication involves not only listening to the spoken language, but also observing the 'paralanguage'; the state of emotion; the tone of the voice; facial expression; eye contact; non-verbal gestures and body language.²⁹ Observing both the verbal and non-verbal communications between parent and child also provides insight into the sort of relationship they have with each other and while parents may be able to hide their feelings, children's feelings 'leak out' in their body language.

Assessment continues with a 'free-ranging enquiry' into memories of the birth, the pregnancy, the early weeks and significant events and milestones in the baby's life story, followed by questions about the parents' relationship with each other and with their own parents, in order to understand the family context of the particular child.²⁷ Part of the function of the assessment is also to help the parents to 'hold in mind' the perspective of the child so that a shared understanding can be reached of the meaning behind behaviour, of the function of behaviour as a way a child can express their feelings, and how parental and child behaviour influence each other. Observing how parents and children react to each other, talk about each other and express or demonstrate affection towards one another, speaks volumes. Striving to help the parent to foster a more positive perception of the child may be the first step in the process of addressing the behaviour problem. Every child is unique, every parent is unique and every parent-child relationship is unique. The role of the clinician is, therefore, to act as a guide to help the parents explore possible solutions that will be unique to them.³⁰

Conclusions

The National Service Framework for Children (emerging findings), 2003 re-affirms that 'children's mental health is everyone's business' and, with this in

mind, renews the government's commitment to provide training for professionals in primary care in order to achieve the goal of a comprehensive CAMHS by 2006.³¹ The trouble is that professionals in primary care are the victims of conflicting priorities: with the trend to treat people at home whenever possible and to devolve responsibilities for the management of many diseases to practitioners in primary care, inadequate capacity in secondary care is addressed at the expense of overburdening an already overworked, underpaid, ageing and diminishing (in the context of need) primary care workforce. Furthermore, training budgets have to be allocated and spent wisely and while there are so many areas of training need, the reality is that child mental health is not as high a priority as, for example, coronary heart disease and stroke, diabetes, asthma or care of the elderly. Like so many other commissioning decisions, a focus on child mental health can only be achieved at the expense of withdrawing support (and money) from other areas. Even though several government documents have suggested that training professionals in primary care in child mental health is a significant contributory factor towards achieving a comprehensive CAMHS, the reality is that the money for training has to come from already overstretched budgets; the professionals themselves are struggling with demanding workloads that make it difficult for them to access training; there are so many aspects of disease management that they require training in, that child mental health is not a priority.

The introduction of primary mental health workers and the development of children's trusts are intended to ensure that every child receives the services they need when they need them, but these new developments will take time to unfold. Across Essex, for example, funding has been identified to provide for one child primary mental health worker for each PCT which means that each worker will be attempting to serve a population of 100 000–130 000. Whilst only a proportion of the population will be aged 0–18, the primary mental health workers cannot be the panacea to all child and adolescent mental health problems. In the early days of their appointments they will need help from tiers 1, 3 and 4 if they really are to make a difference.

If we really do subscribe to the view, enshrined in the most recent green paper, that 'every child matters', then 'every parent matters' and every professional in primary care should be making the effort to support parents in the most important job they will ever do, and thereby help to reduce the burden and impact of emotional and behavioural problems in children.¹⁴ Training programmes such as the one based on the Solihull approach have been developed expressly for this purpose – to give professionals the skills they need to identify relationships at risk, to provide advice and support to prevent minor difficulties turning into major problems and to work with parents and children where emotional and behavioural problems are adversely affecting home, school and social life.¹⁵

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CONFLICTS OF INTEREST

None.

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