SECTION 1

Mental health enhances the capacity of individuals, families, communities and nations to contribute to the social networks and communities in which they exist. Young people who are emotionally healthy have the ability to develop emotionally, intellectually and spiritually; to develop and sustain personal relationships with others; to use solitude constructively and enjoy it; to develop empathy for the feelings of others; to play and learn; to develop a sense of right and wrong and address and learn from everyday conflicts and setbacks. (DfES, 2001)

CHAPTER 1.1

Introduction

WHY DID WE WRITE THIS BOOK?

This book has developed out of our research and work as psychiatrists and psychologists, researchers and counsellors and was inspired by our collaborative research for DfES on Emotional Health and Wellbeing for all in Secondary Schools. We are passionate believers in mental and emotional health for all, and are very excited by the diversity and imaginativeness of the work going on in our schools. This book aims to share and disseminate some of this good practice. We have tried to emphasize interventions that are evidence based.

Recently, concern for the mental health of young people has been high on the political agenda in the UK through such initiatives as Sure Start, National Healthy Schools Standard, *ConneXions*, Excellence in Cities and regularly updated anti-bullying guidelines. An important theme within these policies concerns the increasing incidence of mental health difficulties among the young (Audit Commission, 1999). In this book we argue that schools have a critical part to play in preventing and alleviating the distress experienced by so many young people.

WHAT DO WE MEAN BY 'MENTAL AND EMOTIONAL HEALTH DIFFICULTIES'?

> A mental health problem *can be seen as a 'disturbance in functioning' in one area of relationships, mood, behaviour or development. When a problem is particularly severe or persistent over time, or when a number of these difficulties are experienced at the same time a child is said to have a* mental health disorder. *(*Mental Health Foundation, *1999, p. 6)*

While today's young people seem to face severe stresses that were unknown a generation ago, society still has negative and stereotyped views of mental illness and mental health problems. The sense of shame and embarrassment that surrounds the concept of a mental health disorder contributes to the fact that young people's mental health difficulties are often unrecognized or even denied (Mental Health Foundation, 1999). Only a minority of young people with mental health problems will be referred to and receive help from Child and Adolescent Mental Health Services (CAMHS). The majority will be left to deal with their difficulties on their own or with support from those around them: their family, friends, teacher or social worker. Those with internalizing disorders may become quiet or withdrawn but this is often assumed to be just a part of adolescence; those with externalizing disorders are often seen as disaffected or disruptive (Meltzer, 1999).

MENTAL AND EMOTIONAL HEALTH DISORDERS

Mental health disorders can be divided into two main types: *internalizing* and *externalizing disorders*. Internalizing disorders are those disorders in which the affected person internalizes their difficulties and becomes anxious or depressed or develops physical complaints or an eating disorder. Young people with externalizing disorders, such as conduct disorders and attention deficit hyperactivity disorder (ADHD) have behaviour problems visible to those around them. These two terms roughly equate with the educational terms *emotional and behavioural difficulties*. *Drug and alcohol use* can be both the result of emotional difficulties and the cause of further difficulties.

INTERNALIZING DISORDERS

Depression is one of the most common mental health disorders. Lavikainen et al. (2000) estimate that 2–4 per cent of children suffer from depression, and these rates may be two or three times as high during adolescence. Depression is characterized by sadness and misery, poor concentration, lethargy, social withdrawal, loss of interest in things and a negative view of oneself, the world and the future. Eating may be affected with the young person either eating too little or too much. Young people who are depressed may have other problems such as difficult, disobedient or even aggressive behaviour. They may also be anxious and attempt or complete suicide.

Depression seems to be caused by a number of interacting genetic and environmental factors. Social adversity and the existence of social and emotional problems among parents play a part. In such circumstances, parents may not be able to give the support that the young person so desperately needs. Since the young person is often unable to articulate their difficulties, or simply

complains of 'feeling sad' or 'bored', depressive symptoms can easily be overlooked. Young people who are depressed may not pose the obvious behavioural difficulties shown by those who externalize their problems.

Suicidal thoughts are common among young people with depression, as are feelings of hopelessness and futility. Self-harming behaviour:

- peaks in mid-adolescence;
- occurs in 10 per cent of teenagers aged 15 and 16;
- usually takes the form of cutting;
- is four times more likely in girls than boys;
- occurs in young people who are more likely to employ poor coping strategies such as blaming themselves or drinking alcohol.

Peer relationships affect the risk of self-harming, i.e. the risk is increased by having friends who engaged in suicidal behaviour. However 41 per cent of those who self-harm seek help from friends before acting but they also report that they have fewer people in whom they can confide in comparison with other teenagers.

Death due to suicide is the third leading cause of death in adolescents (Lavikainen et al., 2000). Boys are particularly at risk. Twelve young men take their lives each week in the UK while attempted suicides by young men have nearly tripled since the 1980s; two-thirds of suicidal young men feel that they have no one to turn to for help (Samaritans, 2003). The culture of 'laddism' that requires young men to appear tough prevents many from seeking help with emotional problems. Further information is provided in Chapter 2.10.

Anxiety disorders include *generalized anxiety*, *separation anxiety*, as well as *specific phobias*, such as *obsessive-compulsive disorders*, *social phobia* and *panic disorders*. The development of anxiety in young people is accompanied in adolescence by feelings of unease and uncertainty about personal identity and body image. Separation anxiety may be manifest as excessive clinging to parents or school refusal. *Phobias* are associated with somatic symptoms such as sweating, diarrhoea and, in some cases, panic attacks.

It is crucial that depression and anxiety are diagnosed early so that effective treatment strategies may be applied and that the key people in a young person's life, notably parents and teachers, are aware of warning signs and symptoms.

It is estimated that over one in every hundred adolescents has a serious eating disorder, such as *anorexia nervosa* or *bulimia*. If we include milder versions of the disorder, the rates are substantially higher.

EXTERNALIZING DISORDERS

Pupils with externalizing disorders are much more likely to be noticed in the classroom because of the disruption they cause. Aggressive behaviour is a common behaviour problem during childhood and adolescence. Both poor parental monitoring and constitutional factors, such as hyperactivity and short attention span, have been linked to externalizing disorders. The complexity of the interaction is illustrated in Box 1.1.1.

BOX 1.1.1 LEROY, A DISRUPTIVE PUPIL

Leroy comes from a family where discipline is harsh and physical. His dad always used a heavy hand in punishing Leroy for misdemeanours from as far back as he could remember. The punishments triggered outbursts of anger and aggression on Leroy's part. His mum rarely intervened to protect him for fear of violence from her abusive partner. Since he feared his father's reaction, Leroy targeted his younger brothers. His dad left home when Leroy was 3 years old and things were better for a time. However, his mum remarried and Leroy reacted angrily to his stepfather. He quickly became, in his stepfather's words, 'out of control'. Leroy became known at school as a bully to be feared. His teachers were frankly relieved when he truanted from school (as he often did) because of his intimidating and disruptive behaviour in class. After a series of extremely aggressive episodes against both pupils and teachers, Leroy was suspended from school. His academic work suffered but he did not care since he had won what he saw as 'respect' from his peer group. He became increasingly involved in a gang where his self-esteem grew. By the age of 14 he had a number of convictions for theft and vandalism. By the age of 15 he had been permanently excluded from school.

Thousands of secondary pupils like Leroy are permanently excluded from school each year. The reasons for exclusion tend to be related to general disobedience or physical aggression against staff and other pupils and the disruption of lessons (Hayden, 2002). Even though the number of exclusions decreased from 12,668 to 9,210 between 1996 and 2001, some sub-groups of young people are particularly at risk. For example, boys are significantly more likely to be excluded than girls as are Afro-Caribbean pupils. As a boy of African-Caribbean origin, living in a poor, inner-city district and in a situation of domestic violence, Leroy was especially vulnerable. The evidence suggests that understanding early childhood aggression is very important since its cost to society is great: 'A large proportion of these children remain involved throughout their lives, either in mental health agencies or within the criminal justice system. In other words, we all pay in the long run – personally, finan-

cially or both – when these children are left uncared for and their behaviour problems untreated' (Webster-Stratton, 1999, p. 27).

Recently, the advantage of involving the community in addressing the needs of young people like Leroy has been appreciated. In Box 1.1.2 we give an example of a community-based mentoring project designed specifically to help re-engage disaffected young people in education.

BOX 1.1.2 SOUTHWARK BLACK MENTOR AND INCLUSION PROJECT

This project was initially established to support black pupils excluded from school but has more recently been expanded to target any young people who are in a minority situation. It aims to help young people set personal goals, pass examinations at school and identify what is important to them in life. The scheme works by teaming each young person with a successful adult who has been trained as a mentor to rebuild the confidence of disaffected young people through a range of activities (often grounded in the context of local street culture) and by involving them in an appropriate work placement. The mentors also run group sessions on topics such as citizenship, rights and responsibility.

The advantage of this type of mentoring scheme is that pupils do not perceive it as part of school but rather as part of the young person's community. Although the Southwark Black Mentor and Inclusion Project was set up by the black community, mentoring schemes have been found to be successful in supporting other groups that are at risk of social exclusion. They can also be adapted for use within the school community to address the issue of bullying, by enhancing young people's self-esteem and clarifying career paths for participants.

ALCOHOL AND DRUG ABUSE

Rates of alcohol and drug abuse are higher in people with mental health disorders and may lead to further physical and mental health problems. Adolescence is a time when young people experiment more and engage in higher risks than children do. This in itself is a normal part of growing up. Drugs and alcohol play an increasingly central part in youth culture, particularly in urban areas. Young people may suffer harm from their own or others' drinking behaviour. Every year around 1,000 children are admitted to hospital for alcohol-related illness. There are links between high-risk drinking, permanent disability and death. Drug use has similar risks; these vary according to the drugs used (Drugscope, 2001). Drug-related damage such as dependence,

HIV, hepatitis and overdoses has a social impact and is also related to delinquency, crime, stigmatization and social exclusion. The chances of overcoming drug problems are less among people who are disadvantaged. They have fewer positive alternatives and less access to meaningful employment, housing and educational opportunities (Drugscope, 2000). Perhaps a matter of greater concern is the recent evidence showing a clear link between use of cannabis and psychiatric illness (Rey and Tennant, 2002). A longitudinal study of more than 50,000 Swedish conscripts over 15 years showed that use of marijuana in adolescence increases the risk of schizophrenia in a dose response relationship (Zammit et al., 2002). The authors also found that the risk was specific to cannabis as opposed to the use of other drugs.

RISK AND PROTECTIVE FACTORS FOR MENTAL AND EMOTIONAL HEALTH

THE CONCEPT OF RISK

Risk and protective factors relating to mental health difficulties are found at every level in society, including the individual, the family, the community and the wider social context (Rutter, 2000.). *Risk factors* are those factors that render an individual more likely to develop problems in the face of adversity; they do not in themselves necessarily cause mental health difficulties. Risk factors for having a mental health difficulty (Rutter, 2000) include:

- *family factors*: violence, abuse, neglect, discordant family relationships, being a young person who is looked after outside the family, parental psychiatric illness, inconsistent or unclear discipline, parental criminality, death and loss, rejection by parents;
- *social factors*: poverty, economic crises, deprivation, discrimination, homelessness, rejection by peers, being a member of a deviant peer group;
- *factors in the chil*d: low intelligence, chronic physical illness, hyperactivity, brain damage, communication difficulties, deafness, high alcohol use, drugs and substance abuse, academic failure, premature/under-age sexual activity.

Webster-Stratton (1999) points out that young people who have two or more of these risk factors are four times more likely to develop a mental health problem than other young people; those with four risk factors are ten times more likely to have a mental health problem.

There is evidence that those from African-Caribbean, Asian, refugee and asylum-seeker communities (Goldberg and Huxley, 1992) are at increased risk of mental health difficulties, with the risk being twice as high for males. The problems experienced by these young people are also commonly under-detected.

The evidence points to the need to reduce social exclusion and prejudice in society. Action is currently being taken by the Mental Health Taskforce (see Department of Health website at www.doh.gov.uk) to develop a strategy to tackle the issues surrounding black and ethnic minority mental health, and schools can play a crucial part in the movement to challenge prejudice and social exclusion wherever it happens in particular local contexts.

CYCLE OF DISADVANTAGE

Recent government attention, policy and guidance in the UK has focused on action to tackle the cycle of disadvantage that can trap too many families in breakdown and consequent emotional difficulties for the young people involved. The poorest families in the UK today face a lack of employment and training opportunities and bad housing; they are also more likely to fall ill and to experience mental health problems. A large body of international research indicates strong links between poverty and negative outcomes for children of all ages. Adverse outcomes include behaviour problems and difficulties with peer relationships, adjustment difficulties and delinquency, lesser likelihood of going on to further or higher education and greater likelihood of becoming unemployed as an adult. It is not simply poverty itself but the stresses associated with poverty that make it hard for parents and children to function as well as they might (for a review see McGurk and Soriano, 1998). Such stresses from the community can become part of the school ethos and make them difficult to change (Cowie and Olafsson, 2000).

Protective factors are those factors that act to protect an individual from developing a problem even in the face of adversity and risk factors such as those described above (Clarke and Clarke, 2000). This is also known as *resilience*. Protective factors include:

- *family factors*: supportive relationships with adults, small family size, material resources such as adequate family income, clear and consistent discipline, support for education;
- *social factors*: access to good educational facilities, wider support network, range of facilities available, positive policies in school for behaviour and attitudes, effective anti-bullying policies, good liaison between school and the local communities;

- *factors in the child*: a sense of mastery, participation in activities, sports and outside interests, being a member of a non-deviant peer group, personal attributes such as good health, even temperament, positive self-esteem and intelligence or good social skills, religious affiliation.

Competence, the capacity to cope emotionally with difficulties as they arise, has been shown to be a mediating variable that predicts positive or negative outcomes in mental health; so too is the belief that others are available to offer support when it is needed. Rutter (2000) argues that long-lasting change in an individual's environment, together with a strengthening of his or her competence gives the maximum benefit. Schools play a part in this process. Much less is achieved by inputs – however effective at the time – when overall deprivation and disadvantage continue.

POSITIVE PSYCHOLOGY FOR YOUNG PEOPLE

There is a need for schools to be increasingly aware of ways in which they can create environments that support the young person's natural resilience in the face of the daily adversities of human existence. From the perspective of a positive psychology orientation (for a review see Snyder and Lopez, 2002 in Seligman, 2002), it is useful to focus on strengths, opportunities and assets rather than stressors and individual deficits. Called the sanities, these include: courage, future-mindedness, optimism, faith, interpersonal skills, hope, honesty and perseverance. Successful interventions are those that assist adolescents to focus on hope, optimism and personal growth. For example, in the Penn Prevention Program (Jaycox et al., 1994) children at risk of being depressed are taught to identify negative beliefs, to evaluate these beliefs and to formulate realistic alternatives. They also learn social problem-solving and ways to cope with conflict. Children who complete the programme are significantly more likely to be able to deal with the challenges they face in adolescence than the control group. The results of this study indicate that optimism can be taught. The effects do not wash out but are sustained. One reason for their endurance may be that the learning of skills of competency and resilience is most effective during childhood. The media can portray adolescent boys as aggressive, inarticulate individuals who may not be open to developing competency and resilience skills but Frosh, Phoenix and Pattman (2002) found that, contrary to expectation, the adolescent boys in today's society are attempting to forge new and more flexible masculine identities. The ways in which boys act as 'masculine' are contradictory and 'multiple'. Some of these versions of masculinity emphasize toughness and aggression, but they need not. All the boys in their sample engaged in thoughtful and perceptive discussions about their feelings, including fears over friendships, disappointment with parents, anger at

unavailable fathers and fears and aspirations for the future. The boys often spoke poignantly about losses and also about how much value they placed on parents who attended to them sensitively and seriously, and how disappointed they were by parents who did not.

Interventions that focus on optimism and overall quality of life seem to enhance positive frames of mind for all children, both boys and girls, as well as for those with particular stressors or difficulties.

IS THERE EVIDENCE THAT WE CAN INFLUENCE EMOTIONAL HEALTH AND HELP CHANGE THESE BEHAVIOURS?

In the chapters that follow, we present a range of strategies that have been found by practitioners to help young people in distress. We have tried, where possible, to focus especially on those methods and policies that have been scientifically evaluated. While the emphasis of this book is on practice in the UK, we have cast our net widely in the international field in order to capture the best practices addressing the issue of young people's emotional health and well-being.

We aim to present a framework for educators and policy-makers to:

- promote the emotional health and well-being of young people in schools;
- create school-based policies and practices grounded in knowledge about mental health issues relating to young people.

It is hoped that this book will assist:

- teachers and those who work directly with young people in secondary schools in the development and implementation of mental health promotion programmes within their particular context;
- policy-makers in the integration of mental health promotion within educational policies.

There is clear evidence of the effectiveness of a wide range of mental health promotion programmes. The best interventions focus on more than one factor. Certain elements seem to be crucial:

- The intervention should involve relevant parts of the social network of the target group, such as parents, teachers or family.
- They should intervene at a range of different times rather than once only.
- They should use a combination of intervention methods, e.g.

social support and coping skills.

The UK Health Education Authority (1997, p. 13) defines mental health promotion as 'a kind of immunisation, working to strengthen the resilience of individuals, families, organisations and communities as well as to reduce conditions that are known to damage mental well-being in everyone, whether or not they currently have a mental health problem'. We look to promote mental health at three levels:

- strengthening individuals or increasing emotional resilience, e.g. building self-esteem, coping or life skills;
- strengthening communities, e.g. anti-bullying strategies or after school care clubs;
- reducing structural barriers to mental health, e.g. fiscal policies to reduce inequalities.

(adapted from Health Education Authority, 1997)