Iriss

Using evidence for change

Social Worker Contribution to the Multidisciplinary Team in Preventative Approaches for Children and Young People at Risk of Mental Health Issues:

Evidence from published research

Alison McAughtrie, NHS Education Scotland

Edited by Stuart Muirhead, Iriss

December, 2016

THE NATIONAL EVIDENCE SEARCH & SUMMARY SERVICE

NHS Education for Scotland

Contents

Introduction

This evidence summary addresses the following questions:

- How effective are first-tier preventative therapeutic approaches in preventing children progressing to more severe mental health problems which need more intensive healthcare interventions?
- How and where have these approaches been implemented?
- What are the factors for success?
- How far have social services staff been involved in implementing these approaches?

There was also an interest in focussing on poverty as a context for evidence if available.

A search was conducted in the following databases and online resources to find relevant articles to answer these questions: Social Care Online, Cochrane Library, PsychInfo, Medline, Social Services Abstracts, ASSIA, IDOX, Iriss, the Scottish Government, CELCIS, EPPI, SCIE, NSPCC, Epistimonikos, Centre for Youth and Criminal Justice, Campbell Collaboration, and Google.

Relevant results were selected based on the exclusion criteria. Results went through screening until a final list was created. This was then used to create a summary which addresses the questions asked. Only results for which full-text was available online are included in the summary, though all relevant results are included in the summary table and reference list (for information on how to obtain the full text, see the links provided with each reference).

There was little evidence to be found which looked specifically at the role of social services in prevention and early intervention. Reasons suggested for this absence of evidence are that: social services tend only to get involved when a more serious level has been reached; social services staff have been resistant to getting involved in what is perceived as a ‘health issue’; there is a

lack of training and feeling empowered; the multi-agency complexity of what social services do makes it difficult to assess their specific impact.

However, it is noted that social services staff are well placed to identify children at risk of mental illness, are already involved with children who may benefit from interventions the most and so have the relationships in place, and have the opportunity to communicate with other services. There are a couple of examples highlighted (Seamab's branding and the IVY intervention) where social services staff have worked to try and prevent serious mental health issues developing. As with all the examples found in this search (and supported by the conclusions of systematic reviews), there is a lack of solid longitudinal analysis and more research is needed to assert that prevention and early intervention strategies are effective.

The numbers found in the text align to references at the end of the report.

Summary

Child mental health is an issue of international concern, with it being widely recognised that the earlier it can be tackled, the better [3, 4, 18, 25, 29, 38]. There are high relative rates of mental ill health in young people, but they are less likely to seek help [7]. Early interventions and preventative strategies have been developed by various authorities and organisations to try and stop childhood problems developing into more serious mental illnesses but the evidence for the effectiveness of such approaches is limited.

Approaches have taken the format of face-to-face or computer-based; targeted to specific 'at risk' groups or universal; and while many can be delivered by any trained professional, the majority found in the literature tend to be delivered by – or with the support of – a mental health professional. While using non mental health professionals could be a cheaper short-term option, studies show that programmes delivered by them, or by

teachers who had been specially trained by them, had the most positive benefits on mental health in children and young people [3, 8].

Prevention research - proving that something did not happen as a result of a single action – is inherently tricky [10, 38] and all of the literature states that more longitudinal research is needed. Even where effectiveness is shown, there are issues with trying to generalise programmes from controlled environments into community settings; with things like resource limitations and provider limitations being factors [38].

Effectiveness of prevention/early interventions

Programmes which are targeted at specific children deemed to be more at risk of mental ill health may be more effective than universal ones; though the evidence is mixed [6, 7, 8, 10, 22]. One group identified as benefiting from preventative strategies are children from divorced families; one study finds the positive mental health outcomes from the New Beginnings Programme (NBP) for divorced families were sustained after 15 years [22].

Programmes which focus on positive psychology may reduce the symptoms of anxiety and depression [7]. FRIENDS is a CBT-based programme for children diagnosed with anxiety disorders [18, 30]. It has been named by the WHO as “the only evidence-based programme proven to yield positive results at all levels of intervention for anxiety in children and young people” [18: p555]. Penn Prevention Programme is a school-based, CBT programme involving role-playing, group discussion and videos to promote positivity – a 50% drop in levels of depression has been recorded [25].

The majority of interventions identified were CBT-based [7, 8, 10, 11]. Evidence for the effectiveness of CBT approaches is inconsistent [7, 10]. Positive psychology (the promotion of well-being and resilience, rather than

the alleviation of psychological symptoms) methods may offer more reliable effectiveness than the usual, CBT-based interventions [7].

Targeted, online interventions can have benefits for specific populations at risk of mental ill health (for example, children of divorce) [6, 22]. Online programmes can be efficiently disseminated and accessed, and address the financial and geographical barriers that may exist in accessing or providing interventions for mental health [6, 11, 14]. Online programmes show early signs of effectiveness, but more long-term studies are needed [6, 11]. As some elements were specific (e.g. anger management only showed effectiveness on violence reduction) this can also be an argument for the need for targeted interventions in some cases [38].

CELCIS are working with other organisations to look at developing training programmes for education staff around attachment theory and practice [31: p5]. Previous research suggests that promoting attachment in an educational setting can improve attainment and achievement in at-risk groups of young people [31].

For children affected by trauma, phased approaches are recommended; if a phased approach is not used then interventions could be ineffective or even re-traumatizing. Beyond avoiding poor mental health, such approaches, when successful, can make children more resilient than their non-traumatized peers. Models include: The Attachment, Regulation and Competency (ARC) approach; and Real Life Heroes (RLH) [35: p15].

For children who deliberately self-harm, it was found that there is no effective primary prevention (though there are some interventions that can help to reduce it) [37].

Although evidence-based prevention programmes for young people's mental health can be identified, there is a lack of evidence for their impact or issues with the implementation of them. Boustani et al (2015) identified some common elements across prevention programmes which can be categorised

under the broad themes of problem-solving skills, insight building (including self-awareness), and communication skills [38].

School-based interventions have been shown to be cost-effective [3, 12]. Additionally, schools have a wide and universal reach, are accessible to children from a variety of backgrounds, have direct access to children at a critical stage in their development, and are already environments and infrastructures designed for emotional, academic and social learning [4, 12]. Evidence about the effectiveness of universal and school-based programmes is however mixed and more long-term studies are needed [8, 10].

Similar assumptions about the reach of community-based interventions could be made, but the evidence shows that identified programmes and interventions cannot be effectively generalised.

Approaches

Approaches which focus on anxiety and depression are common as these are common mental health issues [5] which often overlap, and can lead to serious psychiatric, social, academic, and behavioural problems [3, 8, 10]. Despite this, only 20-30% of children with an anxiety disorder are identified to mental health services [5: p910]. Community-based, universal, preventative programmes have been found to have positive effects on anxiety and depressive symptoms – at least in the short term – particularly in low-income countries [4] but more evidence is needed [4, 5]. The effect of interventions on anxiety in particular is very mixed [4, 10].

Smith (2002) highlights successful school interventions such as anti-bullying initiatives, structured parenting programmes, social awareness learning, problem-solving and emotional development skills, and impulse control. Although there are many different approaches available, the report identifies which features are common to all effective interventions: systematic skill

training; building trusting relationships; gaining the support of parents or carers; and having a sense of the wider community [25].

Types of online approaches identified by Clarke et al (2015) were: online stress-management tools, a self-monitoring mood app, a blog-based intervention, and online support groups and therapy sessions [11].

Bite Back is a 6-week, online, community-based positive psychology programme for 12-18 year olds, found to be effective in increasing wellbeing and reducing depression, anxiety and stress in an unstructured, community setting. The effects of the programme were greater for young people who were the most engaged. When the programme was delivered in a structured, school setting, the effects did not transfer [7].

Exercise may be an effective intervention if it is delivered selectively [5], though Christensen et al (2010) found that it was not beneficial for anxiety and stress [10].

Dyadic Developmental Psychotherapy (DDP) is delivered by a psychologist to families of children who have experienced harmful events to help them develop parenting strategies to build relationships with the children they look after [31].

Seamab's 'Sea Changers' branding is a collection of characters which represent emotions (angry/calm/brave etc.). These have been adopted by children as a way to express their emotions or help them deal with difficult situations which has had a positive effect on their emotional wellbeing [31: p6].

Professor Michael Smith writes about Adverse Childhood Experiences (ACEs) which can help identify the likelihood of children developing mental ill-health – those who experience 4 or more have only a 20% chance of staying healthy in adulthood [31: p3]. Thinking about ACEs can help target interventions to prevent lasting harm and he sees it as within the duty and concern of corporate parents to look at ACE reduction. 3 strands for preventing lasting

harm are identified: reducing ACEs; encouraging secure attachment; and developing communities which encourage attachment [31].

Neurosequential Model of Therapeutics (NMT) brings together information about the child to determine their neurobiological developmental age (rather than their chronological age) and use this as the basis to inform which therapeutic intervention(s) is most appropriate [35].

Inequalities

There is a link between poor mental health and long-term socio-economic outcomes [4, 18], and the prevalence of mental health issues is higher for young people from lower socio-economic status, ethnic minorities, and those living in rural or remote areas [12].

“Mental health is inequitably distributed as people living in poverty and other forms of social disadvantage bear a disproportionate burden of mental disorders and their adverse consequences” [4: p2]

It is the most difficult to implement programmes in areas of deprivation, yet these are where they are most needed, and where the potential impact would be greatest [38].

One method which has been shown to reduce inequalities and raise attainment is the Early literacy and Learning Model (ELLM) which works on the principle that improving literacy can improve self-esteem and mental health [18].

Barry (2013) finds that preventative interventions for mental health are being effectively implemented across a range of low and middle income countries however, more evidence is needed [4]. Additionally, there is a problem in generalising results to other areas; particularly as approaches to mental health need to be culturally sensitive [4, 10, 11].

Offering prevention interventions in community or primary care settings makes them more accessible to underserved populations [5].

Social services involvement

There is little evidence to be found on the role of social services staff in early intervention or preventative approaches. This is despite England's National Services Framework for Mental Health identifying tier 1 advice and treatment as that which is "provided by practitioners in universal services" [23: p1009].

Wellbeing should be (and needs to be) seen as the job of all people involved with looked-after children: foster carers; kinship carers; residential care workers; teachers; nurses; social workers; service managers; local and Scottish Government officials; the third sector; families; and young people themselves [31: p4].

Makinson et al (2009) declare that social services have failed to offer enough support for the mental health of young people who are looked after away from home – proven by poor outcomes such as higher rates of mental health problems, substance misuse, and poor general emotional wellbeing. They believe that it is important to be mindful of, and develop, mental health services for young people who are vulnerable, despite the difficulty in proving outcomes [32].

In Moray, Action for Children (AFC) units target children and young people who are looked after away from home. AFC residential staff were given training around young people's mental wellbeing, which resulted in them feeling better able to recognise issues and confidently support the young people they looked after. The training and consultations were multi-agency which can improve relations and communications, and may lead to better access to early intervention services [32].

There is recognition that there needs to be a cultural and attitudinal change to allow social services staff to become more involved [23, 29]. They possess a unique skill set (for example: experience of encouraging participation in care plans; access to social networks and activities; encouraging involvement in the community; acting as advocates for service users; pushing

empowerment for service users; using self-directed support; experience of joined-up working) and position which can benefit the identification of children needing help and the effectiveness of early intervention approaches [23, 26, 29]. Any staff who are not mental health professionals, but are expected to deliver effective early intervention or prevention approaches need to be specifically trained though [8, 14, 29].

Social services staff often already have existing relationships with children and families who need interventions which can help to ensure that young people are made to feel included and want the help offered to them as being forced to engage can negate the positive effects of any programme [7, 29].

Prevalence of mental health issues in children involved with social services

Fraser et al (2014) describe a US initiative designed to allow child welfare workers to identify and respond early to traumatised children. Complex trauma left untreated can have negative and serious consequences in later life, and children involved with child welfare services were identified as more likely to have experienced traumatising events. The Massachusetts Child Trauma Project (MCTP) required staff to undergo intensive training; be self-aware to the dangers of burnout and traumatic stress; be knowledgeable about trauma-informed practice and the impact of trauma; be culturally sensitive; and ensure that resilience and long-term outcomes related to trauma are included in the child's care planning. Trauma Informed Leadership Teams (TILT) have been put in place to increase responsiveness to traumatised children and families. There was no discussion of the effectiveness of the MCTP on long-term mental health outcomes and the initiative is still ongoing [14].

Mental health problems are also found to be more prevalent in children who are looked-after [27] and so actions to prevent mental illness should already involve social services. Social workers are ideally placed to use prevention

strategies for children which increase the protective factors associated with children's mental health when working with vulnerable families [29].

Results from a survey carried out in 2002-03 into the experiences of residential workers and the mental health of the children in their care identified high levels of complex needs in the children they worked with including those with formal mental health diagnoses [33].

There is a particular problem for young people involved in the criminal justice system in accessing mental health help – even though they are more likely to have mental health/potential mental health needs. Barriers to service provision are: waiting lists; poor transition services; over-reliance on medication; inconsistency in clinicians; and poor inter-agency working [36]. The IVY (Interventions for Vulnerable Youth) project aims to help young people who have an identified mental health need but do not meet CAMHS criteria for help. It is a multi-disciplinary, tiered approach (with social workers formally involved from Level 1).

Ideological/professional barriers

Woodcock (2009) has suggested that there are complex and deep-rooted reasons for social workers specifically not being present in early intervention or prevention strategies - many of the obstacles being individual and ideological. There appears to be a lack of common language between professionals, with social workers more reluctant to use the term 'mental health' as it is seen as a clinical diagnosis, or to label infants as needing mental health treatment. There is more of a tendency to see issues as 'family problems' rather than of the individual child. This can lead to delays in referrals to the correct specialist services and perhaps confuse communication with other professionals who use a different lexicon [23].

There is a culture in social work of respecting the integrity of the individual and the 'state intrusion' perceived of preventative strategies may at times contradict this [29]. Social workers may feel that they do not want to take the

responsibility for decisions related to 'health'; either because they do not feel qualified to do so, or because they see themselves as advocates for the service users and 'diagnosis' (or labelling) can lead to stigma [23, 29].

Woodcock asserts that:

"if social work services are to be in a position to meet the NSF standards for infant mental health, then social workers need to attach increased positive emphasis and openness to mental health as a crucial component in their assessment and support of infant well-being" [23: p1020].

Walker (2005) however sees the issue not necessarily that social workers are not involved in preventative strategies, but that their involvement is so entwined with other work and services that their impact cannot be easily observed. They are not traditionally seen as an integral part of prevention strategies, and their interventions are not as easily defined as those of other professionals [29].

Evidence barriers

Preventative interventions need to be incorporated throughout all stages of the child's life and the dimensions of their: living situation and environment; family and social relationships; social and anti-social behaviour; physical and psychological health; and education and employment [29: p12]. Although a number of prevention programmes, involving social services, have been developed based on these dimensions (Sure Start, On Track, Children's Fund, Scottish Executive's Crime Reduction Initiative), it is difficult to assess effectiveness across such a broad and complex range, with some impacts not being identifiable for a number of years [29].

The lack of evidence for social services staff's role in prevention could also reflect the tendency for their involvement to arrive after a problem has been identified and end before any long-term outcomes can be identified or proven [29].

System barriers

Barriers to accessing help for young people in residential care were mainly the young person refusing or being unable to engage, or lack of willingness from other services to get involved and the lack of integration between services. “The system itself was frequently reported as failing children and exacerbating their problems” [33: p7]. Problems in the systems leading to no early intervention meant that problems became more entrenched; with workers feeling powerless to help. Lack of funding for specialised interventions or therapies and not enough staff to give young people the one-to-one support they needed [33].

Even with training, residential carers reported that they would like direct (regular, if not immediate) access to a trained professional to support them. Reported need for structured support in getting a child therapeutic help, including easier access to external help [33, 35].

Systems in crisis which are not adequately staffed, resourced or funded can themselves be limiting or damaging to the mental wellbeing of children; the “care system may potentially create further damage rather than supporting recovery” [35: p16].

References

1. Reshaping Child Welfare's Response to Trauma: Assessment, Evidence-Based Intervention, and New Research Perspectives. (2013), Research on Social Work Practice, 23, No full text online.
2. An exploratory study of mental health interventions with infants and young children in foster care. 2016. Journal of Family Social Work,19, No full text online.
3. Ahlen, J., et al. (2015), Universal Prevention for Anxiety and Depressive Symptoms in Children: A Meta-analysis of Randomized and Cluster-Randomized Trials Journal of Primary Prevention, 36, 6, pp. 387-403.
4. Barry, M.M., et al. (2013), A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries BMC Public Health, 13, pp. 835.
5. Bennett, K., et al. (2015), PREVENTING CHILD AND ADOLESCENT ANXIETY DISORDERS: OVERVIEW OF SYSTEMATIC REVIEWS Depression & Anxiety, 32,12, pp. 909-918 .
6. Boring, J.L., et al. (2015), Children of divorce-coping with divorce: A randomized control trial of an online prevention program for youth experiencing parental divorce. Journal of Consulting & Clinical Psychology, 83, 5, pp. 999-1005.
7. Burckhardt, R., et al. (2015), A Web-Based Adolescent Positive Psychology Program in Schools: Randomized Controlled Trial. Journal of Medical Internet Research, 17, 7, pp. e187.
8. Calear, A.L.et al. (2010), Systematic review of school-based prevention and early intervention programs for depression Journal of adolescence, 33, 3, pp. 429-438.
9. Catania, L.S., et al. (2011), Prevention and early intervention for mental health problems in 0-25 year olds: Are there evidence-based models of care? Advances in Mental Health, 10,1, pp. 6-19.

10. Christensen, H., et al. (2010), Community-Based Prevention Programs for Anxiety and Depression in Youth: A Systematic Review The Journal of Primary Prevention, 31, 3, pp. 139-170.
11. Clarke, A.M., et al. (2015), A systematic review of online youth mental health promotion and prevention interventions Journal of Youth & Adolescence, 44, 1, pp. 90-113.
12. Dray, J., et al. (2015), Systematic review of universal resilience interventions targeting child and adolescent mental health in the school setting: review protocol Systems Review, 4, pp. 186.
13. Fitzgerald MM, et al. (2015), Child welfare caseworkers as brokers of mental health services: a pilot evaluation of Project Focus Colorado. Child Maltreatment, 20, pp37-49.
14. Fraser, J.G., et al. (2014), Implementation of a workforce initiative to build trauma-informed child welfare practice and services: Findings from the Massachusetts Child Trauma Project. Children and Youth Services Review, 44, pp233-242.
15. Gillies, D., et al. (2016), Psychological therapies for children and adolescents exposed to trauma Cochrane Database of Systematic Reviews, 10.
16. Gray, M. (2014), The swing to early intervention and prevention and its implications for social work., British Journal of Social Work, 44, pp1750-1769.
17. Hetrick S.E., Cox G.R., Witt K.G., Bir J.J.andMerry S.N. (2016), Cognitive behavioural therapy (CBT), third-wave CBT and interpersonal therapy (IPT) based interventions for preventing depression in children and adolescents Cochrane Database of Systematic Reviews 2016.
18. Membride, H. (2016), Mental health: early intervention and prevention in children and young people British Journal of Nursing, 25, 10, pp. 552.
19. Sassen, G., et al. (2005), Art from the Heart: A Relational-Cultural Approach to Using Art Therapy in a Group for Urban Middle School Girls Journal of Creativity in Mental Health, 1 ,2, pp. 67-79.
20. Tennant, R.e.a. 2007, "A systematic review of reviews of interventions to promote mental health and prevent mental health problems in

children and young people", Journal of Public Mental Health, [Online], vol. 6, no. 1, pp. 25-32. No full text online.
21. Whyte, S. et al. (2008), The Strengths and Difficulties Questionnaire: A Useful Screening Tool to Identify Mental Health Strengths and Needs in Looked After Children and Inform Care Plans at Looked After Children Reviews? Child Care in Practice, 14,2, pp. 193-206.
22. Wolchik, S.A. et al. (2013), Fifteen-year follow-up of a randomized trial of a preventive intervention for divorced families: effects on mental health and substance use outcomes in young adulthood. Journal of Consulting & Clinical Psychology, 81, 4, pp. 660-673.
23. Woodcock, J. 2009, "What are child-care social workers doing in relation to infant mental health? An exploration of professional ideologies and practice preferences within an inter-agency context", British Journal of Social Work, [Online], vol. 39, no. 6, pp. 1008-1025.
24. Yoshikawa, H., et al. (2012), The effects of poverty on the mental, emotional, and behavioral health of children and youth: Implications for prevention. Psychologist 67, pp272-284.
25. Smith, R. (2002). Research review: promoting children's emotional health.
26. SCIE (2008). Research: the role of social work in mental health services.
27. Luke, N. (2014). What works in preventing and treating poor mental health in looked after children? Executive summary.
28. NESTA (2012). Prevention and early intervention in children's services.
29. Walker, M. (2005). The statutory social worker's role in prevention and early intervention with children.
30. The Scottish Government. (2015). The matrix evidence tables: children & young people.
31. CELCIS, REACH Magazine, Issue 6 [Autumn 2015]. Focus on emotional wellbeing.
32. Makinson, J. et al. (2009). Mindful care: the pilot of a new mental health service for young people who are looked after away from home in Moray. Scottish Journal of Residential Child Care, 8(2), pp18-25.

33. Furnivall, J. et al. (2007). Hard to know what to do: how residential child care workers experience the mental health needs of young people. Scottish Journal of Residential Child Care, 6(1), pp1-8.
34. Furnivall, J. et al (2012). Attachment matters for all: an attachment mapping exercise for children's services in Scotland.
35. Furnicall, J. et al. (2014). Trauma sensitive practice with children in care. IRISS Insights.
36. Dyer, F. et al. (2014). Mental health difficulties in the youth justice population: learning from the first six months of the IVY project. Centre for Youth and Criminal Justice briefing paper.
37. Social Care Institute for Excellence (2005). SCIE research briefing 17: Therapies and approaches for helping children and adolescents who deliberately self-harm (DSH).
38. Boustani, M.M. et al. (2015), Common elements of adolescent prevention programs: minimizing burden while maximizing reach Administration & Policy in Mental Health, 42, 2, pp. 209-219.
39. Hardy, C. et al. (2015), Mental health screening and early intervention: Clinical research study for under 5-year-old Children in Care in an inner London borough Clinical Child Psychology and Psychiatry, 20,2, pp. 261-275.
40. Opler, M. et al. (2010), Primary psychiatric prevention in children and adolescents. Annals of Clinical Psychiatry, 22,4, pp. 220-234.
41. Siegenthaler, E. et al. (2012), Effect of preventive interventions in mentally ill parents on the mental health of the offspring: Systematic review and meta-analysis Journal of the American Academy of Child & Adolescent Psychiatry, 51,1, pp. 8-17.