

EBPU

Evidence Based
Practice Unit

A partnership of



Anna Freud
National Centre for
Children and Families

Key findings

2018

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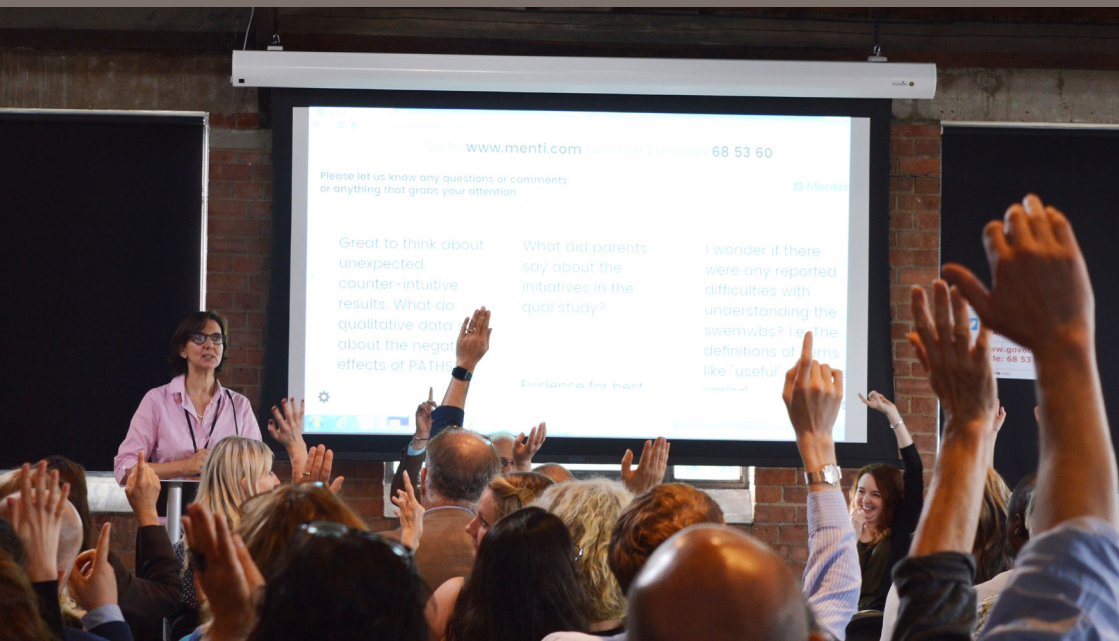
Bridging research and practice in child mental health

About us

Founded in 2006 as a collaboration between UCL Faculty of Brain Sciences and the Anna Freud National Centre for Children and Families, EBPU bridges cutting-edge research and innovative practice in children's mental health.

We conduct research, develop tools, provide training, evaluate interventions and disseminate evidence across four themes:

Risk Resilience Change Choice



Our vision

Our vision is for all children and young people's wellbeing support to be informed by real-world evidence so that every child thrives.

Our mission

Our mission is to bridge the worlds of academic research and clinical practice to ensure that training, tools and support are informed by the latest evidence.

Our values

Our values are at the heart of everything we do. We are:

- children and young people centred
- committed to evidence-based practice
- open to challenge
- rigorous in our work.



Our ethos

- All research is provisional and raises as many questions as it answers.
- All research is difficult to interpret and to draw clear conclusions from.
- Qualitative research may be vital to elaborate experience, suggest narratives for understanding phenomena and generate hypotheses but it can't be taken to prove anything.
- Quantitative research may be able to show hard findings but can rarely (or never) give clear answers to complex questions.
- Yet, despite all the challenges, it is still worth attempting to encourage an evidence-based approach, since the alternative is to continue to develop practice based only on assumption and belief.

Risk

What is the range of contexts and conditions that put a child or young person at risk of mental health issues?

Poverty is a major risk factor for children developing mental health problems.¹

In 2017, over 30,000 children in Years 7 (age 11–12) and 9 (age 13–14) completed a survey in 114 schools across England. These schools were taking part in HeadStart, a major five-year programme funded by Big Lottery Fund which aims to test ways to improve the mental health and wellbeing of 10- to 16-year-olds in less socially advantaged areas. EBPU leads the evaluation of this work and this is the first year of data collection.

18% indicated emotional problems, and this was more common for girls (25%) than boys (11%). 19% indicated behavioural problems, and this was more common for boys (23%) than girls (15%).

The odds of experiencing mental health problems (whether emotional or behavioural) were increased for children who were eligible for free school meals, had special educational needs or were categorised as a 'child in need'.

Being of an ethnic group other than White reduced the odds of experiencing a mental health problem. Specifically, being Asian, Black, mixed or 'any other ethnic group' reduced the odds of emotional difficulties. Being Asian, Chinese or 'any other ethnic group' reduced the odds of behavioural difficulties.

Increased risk of mental health problems for children who are young for their year group.²

In 2011 we looked at the mental health of over 23,000 11- to 13-year-olds in England.

We found being younger than classmates was associated with increased emotional problems, poorer peer relationships, and a higher impact of mental health difficulties on functioning at school and home. However, the effects overall were small.

High levels of emotional and behavioural problems are associated with reductions in academic achievement over time.³

Links between emotional problems, behavioural problems and academic attainment during middle childhood and early adolescence were investigated.

High levels of emotional and behavioural problems were found to be associated with reductions in academic attainment over time in both primary- and secondary-aged children.



Risk of emotional problems for girls at age 13 is raised for those with body dissatisfaction at age 11.⁴

Between 2008–11 we surveyed over 5,000 primary school pupils (8–9 years at start) and 5,000 secondary school students (11–12 years at start) every year, for three years in total.

For 8- to 9-year-olds, raised levels of anxiety and/or low mood predicted body dissatisfaction one year later for both boys and girls, whereas there was no evidence for the reverse being true.

For 11- to 12-year-olds, raised levels of anxiety and/or low mood predicted later body dissatisfaction for boys. However, in girls, body dissatisfaction predicted later raised levels of anxiety and/or low mood.

We concluded that from age 11, girls develop a distinct risk profile whereby body dissatisfaction drives later raised levels of anxiety and/or low mood.

Teenage girls are at particularly high risk of developing emotional problems and prevalence of these problems seems to be increasing.⁵

In 2014 we examined changes in adolescents' mental health problems between 2009 and 2014.

We found that most aspects of mental health problems remained stable over this time period, apart from the fact that difficulties in boys decreased whilst girls had significantly greater emotional problems in 2014 than 2009.

Resilience

What enables some children to cope better than others in difficult circumstances?

Increased funding for targeted mental health support in primary schools reduces behavioural problems, but does not have an impact on emotional problems or in secondary schools.⁷

In 2011 we undertook a randomised controlled trial of Targeted Mental Health in Schools (TaMHS), which was a nationally mandated school-based mental health programme in England.

Implementation of TaMHS was associated with increased school provision of a range of interventions and enhanced collaboration between schools and local specialist mental health providers.

The study involved over 8,000 children (aged 8–9 years) from more than 250 schools.

Students in intervention schools with, or at risk of, behavioural difficulties reported significant reductions in behavioural problems compared with control school students. However, no such difference was found for students with, or at risk of, emotional difficulties.



High levels of family connection, self-esteem, problem-solving and peer support are associated with better mental health.⁶

In 2015 we examined the child-reported student resilience survey (SRS). The survey is designed to assess the range of external supports and internal characteristics which can potentially be viewed as protective factors supporting resilience.

These are family connection, school connection, community connection, participation in home and school life, participation in community life, peer support, self-esteem, empathy, problem-solving, and goals and aspirations.

7,663 children (aged 11–15 years) from 12 areas across England completed the SRS, alongside questionnaires regarding mental and physical health.

We found the SRS to be an acceptable, feasible and valid measure of protective factors. In particular, high levels of family connection, self-esteem, problem-solving and peer support were associated with better mental health.

Change

What influences change in children's mental health and wellbeing over time?

About half of those receiving specialist treatment show measurable change by the end of treatment.⁸

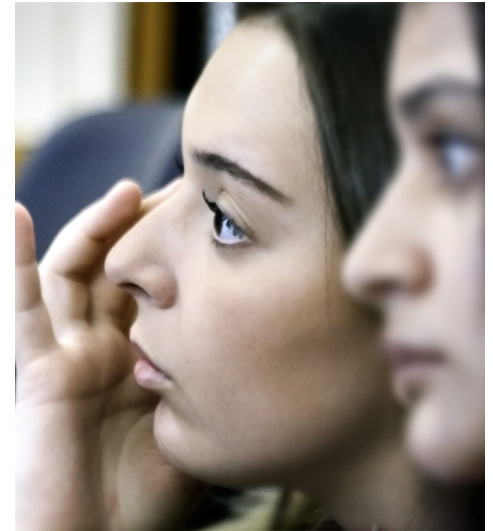
Between 2011–2015 we evaluated child- and parent-reported change in symptoms, functioning or wellbeing for those seen by specialist child mental health services across England.

These services were part of a service transformation initiative called Children and Young People's Improving Access to Psychological Therapies (CYP IAPT).

Just under 6,000 cases (25% of all closed treatment cases) had data about symptoms, functioning and wellbeing at outset and closure, generally from more than one scale. (Mean age: 14 years, 72% female, 87% White).

Of these, approximately:

- 1 in 2 reliably improved (amount of change in score more than likely due to measurement error and no reliable change in the opposite direction on any scale)
- 1 in 3 'recovered' (no scale above threshold at end of treatment)
- 1 in 10 reliably deteriorated (counted as deteriorated if happened on any scale).



Impact of treatment is associated with factors such as which service provides the treatment and some characteristics of the child.⁹

Using routinely collected data from 13 specialist child mental health services across England (2012–16) we looked at the outcomes achieved by over 3,000 young people seen by these services (mean age: 11 years; 53% male).

The results showed there was 4–5% service-level variation in outcomes.

Young people with autism or infrequent case characteristics (e.g. substance misuse) had greater risk of poor outcomes.

Choice

How can children and families be supported to be an active part of decision making?



Embedding shared decision making in therapy - for example, discussing risks and benefits, using decision aids such as choice grids, and focusing on action planning and goal setting - is key to involving children and young people.¹⁰

In 2017 we undertook a review of existing literature to identify and describe shared decision making (SDM) approaches (tools, techniques, and technologies) used in child and youth mental health.

22 publications describing SDM in Child and Adolescent Mental Health Services (CAMHS) were found.

These could be grouped into six approaches:

1. therapeutic techniques
2. psychoeducational information
3. decision aids
4. action planning or goal setting
5. discussion prompts
6. mobilising patients to engage.

Clinicians do not find it easy to embed shared decision making in their work but there are examples of positive practice.¹¹

Between 2011–14 professionals from four UK CAMHS tried a range of tools to support SDM and reflected on their experiences using plan-do-study-act log books.

23 professionals completed 307 logs, which were analysed using qualitative analysis. We identified three states of implementation: apprehension, feeling clunky and integration.

We found that implementation of SDM required clinician preparedness to put in effort, trust in young people, and a flexible use of the approach.

We concluded that while tools may help support SDM, clinicians need to be allowed to use the tools flexibly to allow them to move through the identified states of implementation.

Involving children and young people at every stage of research and co-design is key.¹²

Young people were active participants in the governance, design and testing of Power Up.

Power Up enables young people to record and share ideas and decisions to empower them to take a more active role in therapy. EBPU is also working on two other versions of Power Up; one for parents and one for young people with additional needs.



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Anna Freud National Centre for Children and Families is a company limited by guarantee, company number 03819888, and a registered charity, number 1077106.