Introduction to Child and Adolescent Mental Health

2nd May 2017
Julie Quincey
Independent Safeguarding and Child Mental Health Trainer
Working Together

• Sticking to time
• Giving everyone space to participate
• Respecting difference
• Confidentiality
• Self-care.
Learning Objectives

At the end of this course you will have an understanding of:

• Mental health models
• Attachment theory and the adolescent
• Brain development baby to adolescent
• Risk and resilience theory
• Explore four mental health difficulties
• Explore therapeutic techniques
• Feel more confident about working with young people with emerging mental health difficulties
How we will approach the day

• The day consists of a combination of PowerPoint learning, video watching and discussion, group exercises and therapeutic practice.

• You will feel more comfortable with some aspects than with others but please allow yourself as much as possible to go with the flow.
Define mental health

In your twos please come up with a definition of what mental health is.
WHO definition of mental health

Mental health is described by WHO as: ... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001a, p.1). In this positive sense mental health is the foundation for well-being and effective functioning for an individual and for a community.
Being mentally healthy doesn’t just mean that you don’t have a mental health problem. If you’re in good mental health, you can:

- make the most of your potential
- cope with life
- play a full part in your family, workplace, community and among friends.
Rethink mental illness definition

Everyone has ‘mental health’ and this can be thought of in terms of:

• how we feel about ourselves and the people around us
• our ability to make and keep friends and relationships
• our ability to learn from others and to develop psychologically and emotionally.
• Being mentally healthy is also about having the strength to overcome the difficulties and challenges we can all face at times in our lives – to have confidence and self-esteem, to be able to take decisions and to believe in ourselves.
My teenage self

Please use the paper and pens in front of you and spend two minutes drawing yourself as a teenager, then write down the three things at the time you remember worried you the most.
My teenage self

• Throughout the session today keep revisiting your teenage self try to remember how you felt and looking back what helped at the time and what didn’t

• If you get a moment at lunchtime consider writing down one thing you would tell your teenage self that would have helped using your adult gained experience

• By revisiting your teenage self it helps you before a session with a young person come from a position of empathy
Academic stress  Social anxiety/peer pressure

Family finances  sex

Physical/emotional neglect  Traumatic events

Low self-esteem  Separating or Divorcing Parents

Feelings of helplessness  Social media/bullying
Cases

• Please think of a young person you are currently working with or have worked with. Please do not pick your most difficult case.
• Very briefly write down their presenting problems
• We will use utilise theses case this afternoon
• However throughout the day as we come to new concepts and ideas in your mind please feel free to apply them to your identified case
Three models of understanding mental health and illness

- Biological
- Social
- Psychological
Should one model be dominate?

• Each model has benefits and deficits
• A more integrative approach is to take aspects from each model and view them as connecting spheres
• i.e. genetics, environment, experiences, family history etc. can all contribute to both mental health and mental illness
Biological model

• This model holds that any dysfunction that affects mental functioning can be regarded as ‘disease’ in a similar way to dysfunction that affects other parts of the body.

• In the disease model, a disorder affecting mental functioning is assumed to be a consequence of physical and chemical changes which take place primarily in the brain. Just like any other disease a mental disease can be recognised by specific and consistent signs, symptoms and test results. These distinguish it from other diseases.
• The central tenet of the psychodynamic model is that a patient’s feelings have lead to problematic thinking and behaviour. These feelings may be unknown to the patient and have formed during critical times in their life, due to interpersonal relationships.

• These unknown (or unconscious) feelings are uncovered during therapy.
The behavioural model understands mental dysfunction in terms of theory emerging from experimental psychology.

Symptoms, as understood by the behavioural model, are a patient’s behaviour. This behaviour has come about by a process of learning, or conditioning. Most learning is useful as it helps us to adapt to our environment, for example by learning new skills. However some learning is maladaptive and behaviour therapy aims to reverse this learning (counter conditioning).
Cognitive model

- The cognitive model understands mental disorder as being a result of errors or biases in thinking. Our view of the world is determined by our thinking, and dysfunctional thinking can lead to mental disorder. Therefore to correct mental disorder, what is necessary is a change in thinking.

- This model will be familiar to anyone who has trained or undergone cognitive behavioural therapy (CBT). CBT aims to identify and correct ‘errors’ in thinking. In this way, unlike psychodynamic therapy, it takes little interest in a patient’s past.
Social model

• The social model regards social forces as the most important determinants of mental disorder. The social model takes a broader view of psychiatric disorder than any other model. It regards a patient’s environment and their behaviour as being intrinsically linked.

• In some ways it is like the psychodynamic model, which also sees patients as moulded by external events. However whereas the psychodynamic model sees mental disorder as highly personalized and its determinants not immediately recognizable, the social model sees mental disorder as based on general theories of groups and caused by observable environmental factors.
Exploring concepts

• We will now look at three concepts that are influencing mental health workers and explore some of the concepts
• The three concepts are
• Attachment theory
• Resilience theory
• Brain development and the effects of attachment and trauma
Attachment theory

Piglet sidled up to Pooh from behind. "Pooh," he whispered.

"Yes, Piglet?"

"Nothing," said Piglet, taking Pooh's paw. "I just wanted to be sure of you."
Video on attachment theory

https://www.youtube.com/watch?v=VNOgXv7zTLA
Attachment theorists

Bowlby
Attachment theory meaning of attachment behaviour and safe base

Ainsworth
Maternal sensitivity, strange situation test, three categories of attachment

Main and Solomon
Fourth category Disorganised attachment pattern
Attachment theory

- **Secure (70%) Type B**
  - Children given a positive working model
  - Carer who is emotionally available, sensitive and supportive

- **Avoidant (20%) Type A**
  - Children have a working model of themselves as unacceptable and unworthy
  - Carer who is rejecting

- **Resistant (10%) Type C**
  - Children have a negative self-image and exaggerate their emotional responses to gain attention
  - Carer who is inconsistent
Disorganised attachment

• A fourth category of attachment was identified by Main and Solomon following on from the work of Mary Ainsworth.
• In this situation the child experiences their caregiver as both frightened and frightening, the caregiver may be abusive or emotionally unavailable or unpredictable due to their own trauma.
• The child's attachment behaviour becomes disorganised due to their extreme discomfort they experience in the vicinity of their caregiver.
• These children generally develop serious mental health problems in adulthood including borderline personality disorder.
Attachment and teenagers

• The attachment pattern developed during childhood determines the way in which an adolescent separates from their family during puberty and adolescence, and how they enter into relationships outside the family, including first friendships, intimate relationships, and group relationships with peers.
Secure teenagers

• Securely attached adolescents initiate detachment/separation, and the discovery of new relationships and group identity during puberty, with relaxed curiosity, knowing that their relationships with their attachment figures are secure.

• Such adolescents develop stable new attachments outside the family system. They will be able to oscillate between familial and extra-familial attachments.
Insecure-avoidant teenagers

• Adolescents with an insecure-avoidant attachment pattern tend to direct themselves outward and leave their family prematurely, either because they find it threatening or because they don’t get the emotional support they need.

• They have learned to withdraw when in trouble, or to fall back on their own resources; in conflict situations they tend to respond aggressively with little thought about the social consequences. They do not prefer groups, and when they do join, their membership is shallow and lacking in emotional commitment because they expect little assistance from the group.
Insecure-ambivalent teenagers

• Adolescents with an insecure-ambivalent attachment pattern oscillate between the desire for security in the family and the need to detach, needs they may have difficulty reconciling. They often accuse their family of trying to ‘hold onto’ them. But the truth is that their own confusion about whether to remain embedded in the family or stand on their own two feet is very great.

• Time and again, they try to gain entry to a peer group, but because of their ambivalence about their relationship with their family their peers often make fun of them for their ‘dependency’. And so they only take part in the activities of the group half-heartedly, since they also want to spend time with their family
Insecure-disorganised teenagers

• Adolescents with an insecure-disorganised attachment pattern often show early signs of borderline personality disorders, much as they are seen in adulthood. Family members, friends, and group members find their behaviours and emotions hard to understand when the desire for closeness and help is at issue.
• Their reactions can fluctuate very quickly between seeking closeness and feeling stifled, resulting in belligerent accusations and even violence toward the group. The support they expect isn’t enough, and they may suddenly withdraw, break off a relationship, express rage, or cry and whine like a small child. Occasionally, completely out of touch with reality or any actual incident, they may threaten suicide in desperation.
Borderline Personality Disorder

• Borderline personality disorder (BPD) is a serious mental disorder marked by a pattern of ongoing instability in moods, behaviour, self-image, and functioning. These experiences often result in impulsive actions and unstable relationships. A person with BPD may experience intense episodes of anger, depression, and anxiety that may last from only a few hours to days.

• Some people with BPD also have high rates of co-occurring mental disorders, such as mood disorders, anxiety disorders, and eating disorders, along with substance abuse, self-harm, suicidal thinking and behaviors, and suicide.
Attachment theory and practice

• In your twos
• Take the case you wrote down earlier today and discuss together how attachment theory can help you understand the client
Resilience
Why resilience?

• Mental health and social worker practitioners have long been interested in why some children thrive in adversity and others don’t.

• The premise is that if we can understand what makes a child resilient we can try and build therapeutic techniques and other interventions into our practice and thus enhance resilience.
Resilience is broadly understood as positive adaptation in circumstances where difficulties - personal, familial or environmental - are so extreme that we would expect a person's cognitive or functional abilities to be impaired.
Adversities in childhood

The International Resilience Project, which surveyed almost 600 children aged 11 years, described the most commonly mentioned adversities reported by children. In order of frequency, these were:

• death of parents and grandparents, divorce, parental separation, illness of parents or siblings, poverty, moving home, accidents, abuse, abandonment, suicide, remarriage and homelessness (Grotberg 1997).

This project, which collected data from 30 countries, described resilience as 'a universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity’ (Grotberg 1997:7).
Resilient children

• Resilient children are better equipped to resist stress and adversity, cope with change and uncertainty, and to recover faster and more completely from traumatic events or episodes.
Types of resilience

Three broad types of resilience tend to be described:
• The first type is represented by children who succeed, or do not succumb to adversities, in spite of their high risk status, for example low birth weight babies.
• The second type concerns children who exhibit maturity and coping strategies in situations of chronic stress, such as children of drug using or alcoholic parents.
• Thirdly, resilience may be exhibited by children who have suffered extreme trauma, for example through disasters, sudden loss of a close relative or abuse, and who have recovered and prospered.

Resilience appears to be a dynamic rather than a fixed attribute, having the capacity to emerge in later life after earlier periods of coping problems.
Building resilience

• Please watch this video and then we can discuss how it could be used to build resilience with teens

www.redbridgelscb.org.uk
Building resilience

https://www.youtube.com/watch?v=KF2hQ0XLf6U
Resilience into practice

• Having watched the video, in your twos, take one of your cases and discuss what toward and away strategies your client is using?

• How could you encourage more toward strategies?
Brain development
Brain development

• In this session we will look at baby brain development
• We will explore how the quality of the parent-child relationship is crucial to the way the brain wires itself up, and to the child’s ability to manage (regulate) their own emotions and behaviour, this session will build on the information we have already explored about attachment
A baby’s brain

• When a baby is born it only has half it’s brain
• By aged two the baby’s brain has doubled in size
• It goes from being like a smooth ball to becoming deeply grooved
A baby’s brain!!!
A healthy brain

• The baby in its first two years of life needs lots of nurture, care and love
• What you inherit i.e. your genes is important too
• Given these conditions the baby’s brain develops to its full potential
• In other words the house in which we grow up will influence and shape our brain’s growth
What house did this baby grow up in?

• Most babies have good enough parenting and develop really well
• Some babies have less than good enough parenting
• And some babies suffer abuse
Imagine you’re a baby (1)

• You cry and someone picks you up
• Your wet and your nappy is changed
• You’re hungry and you get fed
• You’re lonely you see a face that is pleased to see you
• You hear kind words about you
• People know when you are distressed
Imagine you’re a baby (2)

- You cry you get shouted at
- You’re wet and you get smacked
- You’re hungry you get something thrust into your mouth
- You’re lonely and a scary monster appears
- You hear nothing but harsh words
- People know when you’re distressed and use it against you
Imagine you’re a baby (3)

• You cry sometimes you’re picked up and sometimes you are not
• You’re wet sometimes you’re cleaned sometimes you are left for hours
• You are hungry sometimes you are fed sometimes they forget
Imagine you’re a Baby(3)

- You’re lonely sometimes you see a friendly face, sometimes a scary monster, and sometimes no one
- You hear kind and harsh words about you, and sometimes no words at all
- People don’t know if your distressed or not
Baby number 1

- Baby number 1 had good enough parenting
- His tummy ache is explained to him and soothed for him
- If he is frightened by a loud noise he is comforted
- If he smiles he is rewarded with lots of attention
- The world is interpreted for him until he is old enough to manage this for himself
- This baby learns how to manage his emotions well when he is older
- His parents give him all of this
Baby 2 and 3

• At best the parenting is inconsistent, these babies cannot predict what will happen next
• At worst the parenting is abusive
• These babies are not soothed on time or at all and therefore will find it hard to make sense of pain or scary things
• The world is not interpreted for them
• These babies when older may struggle to manage their emotions
Nature and Nurture

So nature (genes) and nurture (parenting) are both important when it comes to the baby’s growing brain:

‘They work in tandem, with genes providing the building blocks, and the environment acting like an on-the-job foreman, providing instructions for final construction ... [experiences] - like little carpenters - all can quickly change the architecture of the brain, and sometimes they can turn into vandals ...’

Kotulak, 1993 (Pulitzer Prize-winning series on brain development)
‘The discovery that the outside world is indeed the brain’s real food is truly intriguing. The brain gobbles up its external environment in bits and chunks through its sensory system: vision, hearing, smell and taste ...’

Kotulak, 1993 (Pulitzer Prize-winning series on brain development)
Nature Versus Nurture

‘The digested world is reassembled in the form of trillions of cells that are constantly growing or dying, or becoming stronger or weaker, depending on the richness of the banquet.’

Kotulak, 1993 (Pulitzer Prize-winning series on brain development)
How the Brain grows

• The brainstem - develops earliest and controls the basic and essential functions e.g. blood pressure, temperature, heart rate
How the Brain grows

• The midbrain - develops next and controls appetite and sleep
How the brain grows

• The limbic brain - our alarm system - the seat of emotion and impulse
How the Brain grows

• The cortex - develops last and is where logic, planning and thinking take place. Here we control and manage our impulsive reactions. The cortex is connected to the limbic system and here the brain makes sense of the all the information we receive both from the outside world and within our bodies
What has brain growth got to do with how we have been nurtured loved and cared for?

- Our thinking brain (cortex) is linked to the rest of our brain, but those links are affected by the type of parenting we receive
- Baby 1 will have healthy links and his thinking and emotional parts of his brain will work extremely well together
- Baby 2 and 3 may have poorer links and may over use the emotional part of his brain or indeed shut down his emotions and appear not to react
What has brain growth got to do with how we have been nurtured loved and cared for?

- Caroline Archer talks about healthy and unhealthy roadmaps in brain development
- Where a child has received adequate care and his needs are met at his pace (reciprocity) and where his emotional needs are met (containment) the roads between the emotional brain (limbic system) and the thinking brain (the cortex) are well organised and easy to navigate
- In other words this child can utilise both emotional and thinking parts of his brain and thus is pretty good at emotional regulation and problem solving
- These pathways would look like a healthy tree

Caroline Archer 2003
What has brain growth got to do with how we have been nurtured loved and cared for?

• Where reciprocity and containment has been poor or indeed the parents have been abusive to the child or have been unable to help the child emotionally regulate; the roadmap is disjointed and the connections between the emotional and thinking brain are poor

• These children tend to be only able to utilise emotional strategies or thinking strategies and this hinders their emotional self management and general development. Their brain pathways would look something like this:
The poorly developed tree

- Some of the branches are missing
- The tree is disconnected with itself
What would you see in pre-school

- Baby 1 would be quite secure in his environment
- Could make friends
- Could take turns
- Easily pacified when upset
- Able to manage his emotions reasonably well
What would you see in pre-school

- Baby 2 and 3 may not feel as secure in school
- May be tearful or angry
- May over react or not react at all
- Will find it harder to make and keep friends
- Will struggle to manage emotions
Closing thoughts

• Early experience determines which parts of the brain grow well and which parts of the brain do not grow as well (Healthy tree.... Disjointed tree....)
• Early exposure to negative experiences e.g. abuse and neglect, limits long-term capacity to regulate feelings
• Good enough early attachment i.e. caring, nurturing parenting helps to promote in the child resilience and therefore they cope better with the everyday difficulties we all have to face
“The truth is, much of what we have traditionally believed about babies is false. We have misunderstood and underestimated their abilities. They are not simple beings but complex and ageless-small creatures with unexpectedly large thoughts.”
The teenage brain

• The 0-2 year stage is an enormous growth period for a child's brain
• During adolescence the brain grows again and effectively is remodelled
• The next video aimed at teenagers explores the difficulties this growth and remodelling causes teenagers
Understanding the teenage brain

Your Special Teenage Brain with Nicola Morgan

https://www.youtube.com/watch?v=s9EEee1s74k
Group discussion

• How useful did you find this video
• Could you use it with clients or the ideas within it
• Any other thoughts
Understanding mental illness

• The next section will look at common mental health difficulties
  • Anxiety
  • Depression
  • Self harm
  • Obsessive Compulsive Disorder
Anxiety

https://www.youtube.com/watch?v=SDPW3pdInLk
Exercise on anxiety

• Having watched the last video on common signs of anxiety lets now take a case example.
• Jane is 15 years old she has just started her physics lesson a subject she is skilled in the teacher starts preparing the class for future exam questions. Jane runs out.
• In groups discuss what symptoms of anxiety may be at play here
Living with depression

https://www.youtube.com/watch?v=EJ_S5Rjt_iI
What are your thoughts?

• Lets share how this video made us feel, how it made us think
Internal working models/schemas

• Having viewed the video on living with depression we can see that the person affected has a poor self-esteem and a low opinion of themselves
• If we relate this back to attachment theory and the concept of internal working models
• Bowlby (1969) maintained that a child experiencing their parents as emotionally available, responsive, and supportive will construct a self model as being lovable and competent. Conversely, experiences of rejection, emotional unavailability, and lack of support will lead to the construction of an unlovable, unworthy, and incompetent self model.
Internal working models and schemas

• So the internal working model is in fact a filter.
• All the information the brain receives is filtered through the model or the belief the person has of themselves
• So an IWM I am unlovable works this way
• Someone smiles at you which should make you feel happy the IWM takes the smile and turns it around i.e. that smile is false or if they knew you they wouldn’t smile at you
• These are also known as schemas
Schemas

• A schema is a cognitive framework or concept that helps organize and interpret information. Schemas can be useful because they allow us to take shortcuts in interpreting the vast amount of information that is available in our environment.

• However, these mental frameworks also cause us to exclude pertinent information to focus instead only on things that confirm our pre-existing beliefs and ideas. Schemas can contribute to stereotypes and make it difficult to retain new information that does not conform to our established ideas about the world.
Schemas and cognition

• Cognition means thought
• Everything we experience is processed by our brain through cognition, we interpret meaning to the experience which will be filtered through our existing schema.
• Once the cognition happens it will effect our feelings which in turn will effect our behaviour (the basis of CBT)
You step in dog poo
Solution to dog poo
It’s the end of the world

• The bomb is about to drop you have five minutes what’s the next thing you are going to do
Self harm
Understanding mental illness and self harm

https://www.youtube.com/watch?v=t0ieYSbKySU
Let’s discuss

• Are you aware of other reasons young people self-harm?

• Are you aware of other alternative coping strategies that can be introduced to young people?
Obsessive Compulsive Disorder
Living with OCD

https://www.youtube.com/watch?v=MP4W8150aZg
OCD

• Lets try an experiment
• So how long does it usually take to make a cup of coffee
• Now calculate how long it would take to make a cup of coffee if you are compelled to count to five at each stage, remember if you are interrupted you will need to start the compulsion again
• How do you think it would make you feel
• The next video goes into the connection between anxiety compulsion and rituals
OCD

https://www.youtube.com/watch?v=l8Jofzx_8p4
Skills packs

• In one day we cannot cover all the different techniques from assessment to intervention that can be used with common mental illnesses

• Therefore I have provided a handout that takes the mental health difficulties we have covered and provides you with a list of resources
Lunch

KEEP CALM IT'S LUNCH TIME
This afternoon’s session will:

• Share therapeutic skills
• Explore solution focused therapy approach
• Setting up the therapeutic space
• Creating an alliance
• Goal setting
• Scaling
Share your skills

• In groups of four please can you spend some time discussing and or demonstrating any therapeutic skills you have used in sessions which you are comfortable using with young people or children
• Can one of you on the flip chart paper name the skill and which therapeutic tradition you think it may have come from
• Lets feedback
Therapeutic spaces

• In twos please discuss what you think is a therapeutic space and how we achieve it

• Feedback
Therapeutic space what young people want

- Choice of venue and time
- What information is known and who will get to see it
- If in serious danger or harm information will be passed on
- How to make an appointment to see the professional.
- What are the limits of confidentiality
- How can they contact you
- Will you turn up on time
- Will you cancel appointments
- Reliability is key
- Respect is key
- Being involved in decision making
- Being consulted
- All of the above builds trust
Solution focused therapy skill sharing
Setting up the session

- Welcome the young person
- Congratulate them on coming to the session acknowledge this may have been difficult for them
- Explain who you are
- Explain briefly what you do
- Explain limits of confidentiality
- Explain that they are in charge of the session
- Explain how the session will run
- Ensure they know how long they have
- Keep time let them know five minutes before end of session
The first session

• You need to help the young person define what they want to get out of the session

• Useful questions:
  • If this session has been a success for you what would we have discussed?
  • Do you have a goal that you would like to achieve?
  • Why do you think you have come to this session?
  • I want you to imagine it’s the end of the session and you have found it useful, how will you know it has been useful?

• Explore the goals they identify
• End every session by negotiating if they would like another session
• Suggest they practice the ideas they have had in the session before the next session
• Spend last three minutes summarising the session with LOTS of positive feedback
Subsequent session

• What's gone well since the last session?
• Are your goals still the same or would you like to change them?
• How would you like to use this session?
• Clarify carefully what they want to discuss
• Use this as the structure of the session
• At the end of the session negotiate if they need another session
• Summarise the session giving LOTS of positive feedback
Defining the goals

Useful questions:

• Ok I guess there may be a number of things that are bothering you in one minute - can you let me know what they are?

• Taking all these things that are bothering you, which area would be useful to start with first?

“ I’m going to get clean”

• That’s a pretty big goal, what's the first thing to getting clean do you think you need to do?
From problem to solution

Useful questions:

• So let's imagine you no longer have this worry, what will you be doing instead?

• Let's imagine it's a year from now, what will you be doing, if the way the worry you had is no longer getting in your way?
Externalizing

This basically means taking a problem that is felt personally and then depersonalising it

• Example “I am depressed”
• Response “you find depression sometimes gets in your way”
• Example “I worry about everything”
• Response “If we could describe worry as a thing what would it be”
Externalizing continued

Using a real case

• So you have Danny Devito in your head telling you that you can’t go into school

• Yes he’s always there

• Lets imagine that Danny Devito has shrunk in your head and you can’t hear him so well what will you have done to shrink him

• I’d tell him to shut up and sod off etc. etc.
Possibility laced acknowledgement

• I’m always depressed
• So you’ve been down (been down, instead of are down, suggests to the young person there are times when they are not depressed)
Miracle question

• I want you to imagine you leave here, go home, have tea, watch TV, go to bed and fall asleep. Whilst you are asleep a miracle happens, this miracle sorts out the problem we have been talking about. Now you were asleep so you don’t know the miracle has happened. When you wake what's the first thing that will let you know the miracle has happened,
  • What else?
  • What else?
  • What else?
Mirroring

Example: ‘I’m an idiot’
Response: ‘So you have been feeling like a bit of idiot lately’

Example: I’m so ugly no one would want to go out with me’
Response: ‘So on days you feel ugly you feel no one would want to go out with you’
Decline invitations to blame

Example: ‘My father constantly hit me - it was my fault that’s why I had to move out’

Response: ‘So your father abused you, how in spite of the abuse did you find the courage to move out?’
Moving forward

Example: ‘I’m always in trouble at school’

Response: ‘So we will know when things are better because you won’t be in trouble at school’
‘So if your not in trouble what will you be doing instead’
Use humour

- This is tricky but can be very effective
- Humour is laughing with rather than laughing at
- Humour helps to lift the moment and enables momentum to move forward
- She kicked off for three hours it was awful
- So gold medal standard tantrums then?
Assume times without problems

• Ask and talk about problem-free times then get the detail, what was different? What were they doing differently? - really amplify
• Then you can move towards suggesting they try what has succeeded in the past and use it again
The scale

- 10 = desired goal, problem free land, success
- 9
- 8
- 7 = past successes when things were already better
- 6
- 5
- 4 = visualising one step higher on the scale
- 3 = ? Where you are now
- 2
- 1
- 0 = when things are at their worst
Scaling questions

• Please refer to your handout and let's explore these questions in a bit more detail by using a volunteer

• Does anyone have a SIMPLE problem that we could explore and they would be willing to explore by using scaling questions.
Case workshop

• At the beginning of the today's session I asked you to think of a client that you would like to find ways to work with, please refer back to what you have written

• Would anyone like to discuss their case?

• Let's generate ideas and solutions
Child and Adolescent Mental Health Services

http://www.nelft.nhs.uk/services-redbridge-camhs-service

CAMHS Transformation:

• Away from a tiered service, to the ‘I Thrive’ Model
  http://www.annafreud.org/service-improvement/service-improvement-resources/thrive/

• Wellbeing Hub for triage

• Info, advice and guidance database
Schools: Educational Psychology Service

- Schools as a universal service work with children and families on social, emotional and mental health.
- Every school has an Educational Psychologist and each term s/he visits and holds a planning meeting, usually with the SenCo, who will raise cases for discussion. If the Educational Psychologist and school agree there is a need for direct work with the child then the parents are asked to consent to access their services (e.g. Classroom observation, individual work, group work).

www.redbridgelscb.org.uk
Training Transfer

Three actions to support learning in your team / setting:

• Presentation at Team Meeting, sharing resources with colleagues

• Audit of / updating of current tools used in setting

• Identification of future training needs: 
  http://www.redbridgelscb.org.uk/training-2/
Video links

• Attachment video attachment video slide see slide number 21
• Resilience video see slide 38 resilience video
• Your teenage brain slide 74 your teenage brain
• Anxiety slide 77 go common symptoms of anxiety
• Depression slide 79 living with depression
• Self harm slide 89 understanding mental illness and self-harm
• Living with OCD slide 92 OCD blues
• OCD symptoms slide OCD
References for independent learning

• Bouncing back: How can resilience be promoted in vulnerable children and young people? Grotberg 1997
  http://www.barnardos.org.uk/bouncing_back_resilience_march09.pdf
• Inside the Brain: Revolutionary Discoveries of How the Mind Works Kutalek 1996
• Trauma attachment and Family permanence Caroline Archer and Alan Burnell 2003
• David Chamberlain
Learning Objectives (revisited)

At the end of this course you will have an understanding of:

• Mental health models
• Attachment theory and the adolescent
• Brain development baby to adolescent
• Risk and resilience theory
• Explore four mental health difficulties
• Explore therapeutic techniques
• Feel more confident about working with young people with emerging mental health difficulties
Evaluation

• Please fill in evaluation slips
• Participants will receive a on-line evaluation form and will receive certificate on completion
Thankyou and goodbye