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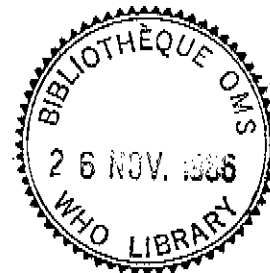
Delphi, 30 October - 5 November 1983

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3 October 1983

National Case Study

CHILD MENTAL HEALTH AND PSYCHOSOCIAL DEVELOPMENT  
IN THE UNITED KINGDOM

by  
Mrs Lea Pearson



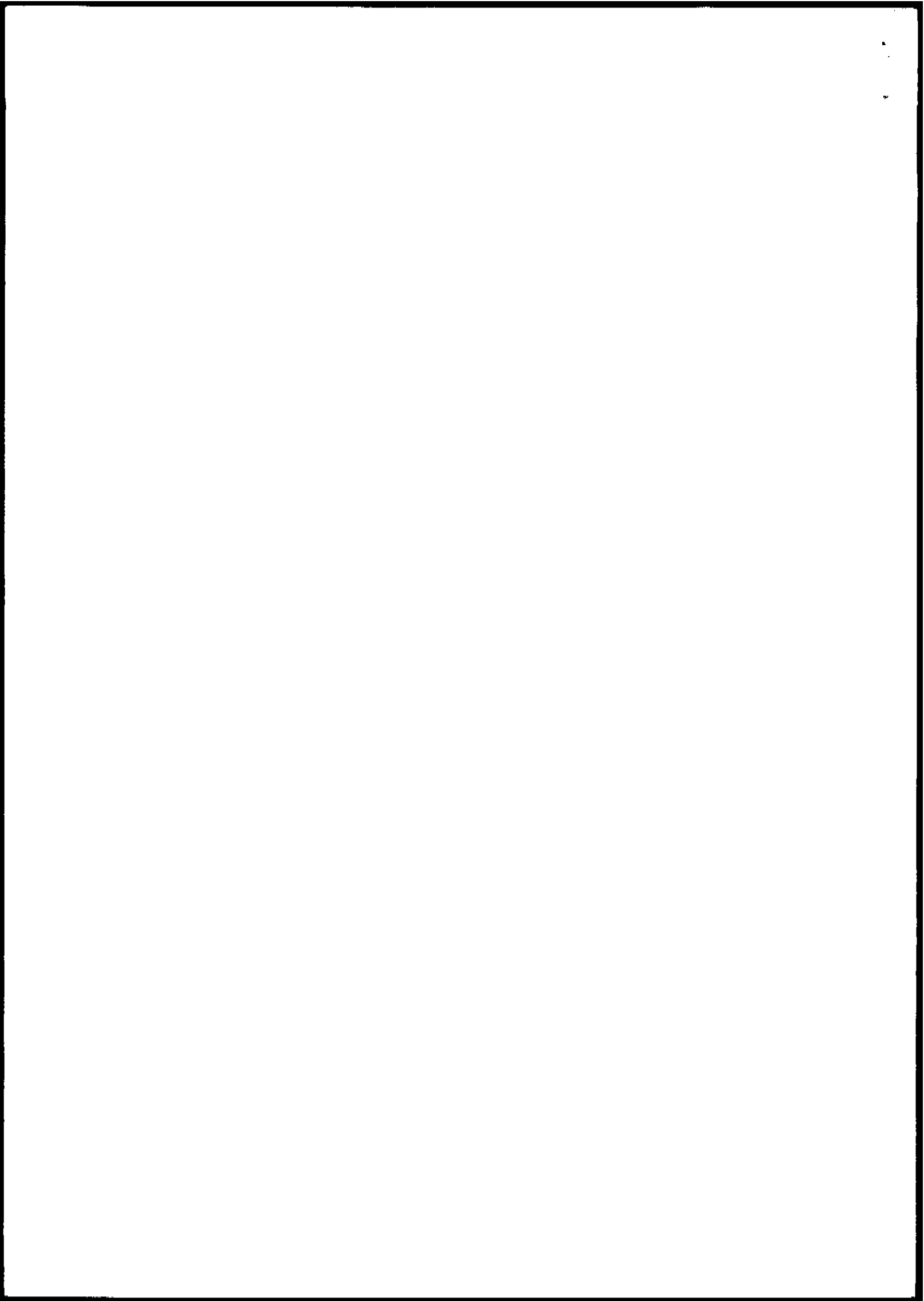
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NATIONAL CASE STUDY

Name of Country: England and Wales.

Date: October, 1983

Names of persons completing study: Dr. Philip Graham,  
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Population of Country 49.2 million

Approximate population under 15: <sup>10.3</sup>  
~~18.6~~ million

DRAFT

October, 1983

## WHO NATIONAL CASE STUDY

## ENGLAND &amp; WALES

## Section 1

The total size of the population of England and Wales in 1981 was 49 million (Great Britain 55 million). The population of children of different ages is shown below.

	<u>Great Britain</u>		<u>England &amp; Wales</u>	
	N (million)	%	N (million)	%
Total:	55.4	100	49.2	100
0 - 4	4.1	7.4	3.2	5.8
5 - 14	7.9	14.3	7.1	12.8
15 - 19	4.5	8.1	4.1	7.4
0 - 19	16.6	30.0	14.3	25.8

Indicators and health

1. Virtually the entire population has access to safe drinking water in the home.
2. The proportion immunised against various diseases was as follows in 1981:
 

Diphtheria	84%
Tetanus	83%
Whooping cough	45%
Measles	55%
Poliomyelitis	82%
Rubella (schoolgirls)	84%
BCG (% vaccinated with negative skin test)	98.5%
3. Virtually the entire population has access to local health care within an hour's walk or travel.
4. All deliveries of newborn children are attended by trained personnel except where delivery is concealed or unexpectedly precipitate. In 1979, 97.4% births took place in an NHS hospital, and 1.4% at home.
5. The proportion of live births weighing less than K2.5 has been relatively constant at 6.5% for some years.
6. Weight for age. No comparisons with WHO standards are available, but the U.K. population is likely to be very close to these standards, which are based on American norms.

7. In 1979 there were 14.6/1000 deaths in England and Wales in the peri-natal period. Infant mortality (deaths under one year per live birth), was 12.6/1000 in 1979.
8. In 1980 the life expectancy at birth was 74.9 years for women and 68.7 years for men.
9. The adult literacy rate defined as the number reporting difficulties in reading was found to be 4% in a general population study of 23 year olds born in 1958 (Adult Literacy and Basic Skills Unit 1983).
10. The gross national product per head in 1979 was approximately 6,100 dollars.

## Section 2

### Socio-cultural and Environmental Factors

i. The most common type of family in England and Wales continues to be of "nuclear" type and to consist of two parents and two children. The mean number of children under 16 years in families where there are such children is 1.8.

Nevertheless, families with this structure, although the most common type, do not constitute the majority (OPCS 1981). There is a wide diversity of other types, especially including two parents with one child, two parents with three or more children, single parent households (now constituting 6.3% of households with children under 16 years), two parents with another adult (usually a grandmother) present etc. Thus only a minority of children live in the stereotyped nuclear family with two parents and two children.

Further, the functioning of a family often involves other family members even where these do not form part of the household. For example Richman et al (1982) found that over 60% of mothers of 3 year olds living in a North London borough saw their own mothers at least once a week.

The child-rearing beliefs and practices of the population are described best in surveys examining these issues, especially those carried out in Nottingham (Newson and Newson 1965, Newson and Newson 1968). Space precludes a summary of their findings, but the most salient trends involve shift towards greater involvement of fathers in child-rearing, and a move towards a more child-centred upbringing. Although it has not been well documented, there was also probably a move towards greater permissiveness with less firm and less physical discipline in the 1960s and 1970s. Nevertheless, the UK remains the only country in Europe in which teachers, who temporarily assume some parental rights while the child is in school, are allowed to use corporal punishment. Despite the changes that have occurred, role definition between fathers and mothers remains reasonably clear in most families with mothers taking the main burden of running the household and looking after the children, and father being the main breadwinner.

ii. The role of women. Until the recent financial recession, there has been a continuing trend for mothers to be involved in part-time or full-time employment, and the official figures probably provide an underestimate. Richman et al (1982) found that 27% of mothers of 3 year olds worked at least part-time and 45% of mothers of 8 year olds. 78% of employed women said that their main motivation for working was the earning of money, but as secondary considerations, 20% said that work provided company and 36% said they worked to get out of the house. Despite equal opportunity legislation, women often work in jobs that are poorly paid, often on a casual basis without union protection. In most areas of work women occupy fewer senior positions than men. There is now an increasing number bringing up children on their own. The number of women who choose to produce and rear a child on their own has also increased but remains very small. Increasingly too, mothers are involved in activities confined to women, such as feminist organizations, health clubs, and political organizations such as the women's peace movement.

iii. Family size, composition etc. As stated above there is a wide diversity of family type and composition with the two-parent, two-child family constituting the most common but by no means the majority of families.

In 1980 the mean age of marriage of women who had not been married before was 22.9 years (24.6 years from 1941 to 1945) and the mean age of a woman at the birth of her first live child was 25.0 years (26.5 years in 1941-45) (OPCS 1980).

6.3% of households containing children have only one adult, and in only about 11% of single-parent households is the single parent the father.

The rising divorce rate has certainly affected the lives of many children. In 1970 the number of children under 16 of couples who divorced in that single year was 71,000 whereas in 1980 it was 163,000, a rise of 230%. It has been estimated that about 1 in 4 children have parents who separate or divorce while they are under the age of 16 years.

iv. Schooling. This is compulsory from 5 to 16 years. School transfer from primary to secondary school usually takes place at 11 years, but a number of authorities have other arrangements with, for example, middle schools taking children from 9 to 13 years. Most schooling is delivered free in state schools, with only 6% of children being educated at their parents expense in independent schools.

Primary schooling is non selective and at secondary age a considerable majority of schools are "comprehensive" or non-selective. Though a minority of education authorities have retained selected "grammar" schools. There is<sup>a</sup> wide variety of provision of special schools for children with special educational needs and this will be discussed in more detail below. In general, at primary level, class size is between 25 and 35 pupils, while at secondary level class size is between 20 and 25 pupils. Partly because of an increasing interest in education and partly because of rising levels of unemployment, an increasing number of 17 and 18 year olds<sup>are</sup> staying on at school.

The influence of secondary schools on personality development, truancy, behaviour and emotional problems and educational attainment has been well documented by Rutter et al (1979) who have shown how the academic ethos of the teachers, their punctuality at lessons, speed of marking homework, and capacity to establish control by a system of reward rather than punishment all influence child behaviour and development.

v. Level of financial benefit and maternity leave.

There is a complex system of payment to families with children in the U.K. that is described below. The actual sums of money involved are not given as these vary. It is important to note that, although they are raised as the cost of living increases, none of the benefits is index-linked.

- a. Child benefit is a cash benefit payable for all children under 16 years (or up to 19 years if in full-time education). Additional benefit is paid to single parents.
- b. Child special allowance is payable to a woman with dependent children who has been divorced and whose former husband dies (a substitute for maintenance payments).
- c. Family income supplement is payable to families with children where the breadwinner earns only a low income.
- d. Supplementary benefit is a benefit for those on low income (unemployed or employed part-time) that is increased depending on the number of children in the household. For a divorced parent receiving this benefit, maintenance payments may be collected by the benefit office.

- e. Attendance allowance is payable to parents of children aged between two and sixteen years who are severely disabled and require a great deal of extra attention by day and/or by night.
- f. Paid maternity leave is payable to women for the first six weeks they stop work, and a maternity allowance is payable for up to 18 weeks. There is a small maternity grant.
- g. Other benefits for those with children on supplementary benefit or family income supplement include free travel to hospital, free medicines and appliances, free school meals, free milk for expectant mothers and children under five, /free school milk (in some authorities), school uniform and clothing grants.

N.B. This list is not quite complete but covers the main benefits. Rather complex rules are applied in each case (other than child benefit) to determine whether the benefit is or is not payable.

vi. Attitudes to the handicapped.

By convention, defects are defined as intellectual or bodily impairments which may or may not result in malfunctioning. Disabilities are defects which do result in malfunctioning. A handicap is a disability which, for a substantial part of a person's life unfavourably affects normal growth or personality development, (Younghusband et al 1970).

There has been a gradual improvement during the past two decades in community attitudes to the handicapped, both physical and mental, and this has been reflected in legislation such as the 1970 Chronically Sick and Disabled Person's Act which requires local authorities to make special provision for handicapped people, and the 1981 Education Act to be described in the next section.

Two trends are discernible. First, there is a movement towards the integration of the handicapped so that they can lead as normal lives as possible. This is reflected in the policy to provide mental health care for both the mentally handicapped and the psychiatrically disturbed in the community rather than in large mental hospitals situated at some distance from their catchment areas, though resources for implementing such policies are limited. / Second, there is an acknowledgement that, integrated or segregated, the handicapped need more special provision to enable them to function as well as possible. The provision of ramps and special toilet facilities in public places,

the legislation requiring large firms to employ a certain proportion of handicapped people, and the special financial benefits (see above) for the handicapped, are reflections of this trend.

Nevertheless, the picture, though improved, is far from satisfactory. Many pre-school playgroups will not tolerate children with mental or physical handicaps; children with epilepsy still meet with prejudice from members of the community; many public places still do not have lifts or ramps and are consequently inaccessible to the handicapped. Attitudes and lack of resources and trained staff are obstacles to the integration of handicapped children in ordinary schools in the community.

## Legislation

### 1. Schooling.

Attendance at school is compulsory between 5 and 16 years. Non-attendance may occur for a variety of reasons, of which a number have mental health implications. Both truancy and school-refusal, unwillingness to attend by virtue of anxiety, are now largely dealt with by firm encouragement to return rapidly, linked to family counselling. Failure to return in school refusal may be followed by referral to a child and family psychiatric department or child guidance clinic: there is wide regional variation in service provision.

By contrast, persistent truancy is more likely to lead to the child being brought to court. If this occurs, those involved in doing so have to decide whether criminal proceedings against the parent or guardian in the adult court, or "care" proceedings (Children and Young Person's Act 1969) in the juvenile court, are to be taken. Juvenile proceedings would be brought on the grounds that the child is not receiving full-time education, and is in need of care and control. Usually, if a case is brought, it is adjourned to see if the child will return to school before being brought back to court, or the child is put on a "supervision order", thus receiving more continuous monitoring and counselling from an education welfare officer or social worker. If this fails, the local authority may decide that the child's needs require him to be placed in residential care.

### 2. Maternity leave.

Employed women are allowed paid maternity leave for six weeks (nearly full pay) plus 18 weeks (maternity allowance). They are also allowed up to 6 months unpaid leave.

### 3. Legal separation, divorce, custody.

Parents who are separating have a duty to continue to provide adequate care for their children, and if they appear not to be doing so, their children may become subject to informal or formal assessment from a social worker (Children and Young Person's Act 1969) as may apparently unprotected children in other circumstances.

The Matrimonial Causes Act (1973) requires divorce courts to consider the welfare of any children under the age of 16 years or still receiving education or training.

In practice welfare reports are rarely requested, and the parents' statements as to the future care of the children are usually accepted. The court must award custody to one or both parents or, if the court concludes that neither parent can provide adequate care, the local authority must take action and, if necessary receive the child into care. Any award of financial maintenance is made in the same court proceedings.

If, as is usually the case, one parent (usually the mother but occasionally the father) is awarded custody, that parent has, for all intents and purposes, full parental rights and duties invested in her or him. However the other parent is usually awarded "access" to the children and this is legally enforceable. Disputes regarding access may be settled informally or by recourse to the courts. Under exceptional circumstances a child may be made a ward of court and placed under the supervision of the family division of the High Court.

#### 4. Child protection, abandonment, child abuse, child labour.

1. Children may require special protection because their parents are not giving them adequate care, because they have been lost or abandoned, because they are at risk of injury, or have been injured or sexually abused, or for a variety of other reasons. A complicated system of legislation, of which the Children and Young Person's Act 1969, is the most important, governs the actions of those involved when these circumstances arise.

Informal protection is provided by enquiries which may be made on the basis of information given by neighbours, friends, the police, or parents and children themselves. This protection may be given by both voluntary agencies such as the National Society for the Prevention of Cruelty to Children (NSPCC) and local authority Social Service Departments. Voluntary supervision may ensue, and voluntary action may include, if the parents agree, reception of the child into residential care.

In an emergency, when a child's safety is immediately in question, a social worker may apply to a justice of the peace for a place of safety order which allows a child to be kept in a safe place such as hospital or children's home for up to 28 days.

In less urgent cases, where it is believed that more formal action is required in the best interests of the child, then "care" proceedings may be taken under Section 1 of the Children and Young Person's Act 1969.

This action is appropriate for a child who is:

- a. Neglected or ill treated.
- b. Exposed to moral danger.
- c. Beyond the control of parent or guardian.
- d. Failing to attend school.
- e. Believed to have committed an offence other than homicide.

Care proceedings may not be taken if voluntary action is likely to meet the best interests of the child. Following proceedings the child may remain at home under formal supervision, or may be received into care, or a variety of other arrangements, such as fostering, can be made. In recent years the number of children received into residential care has decreased, reflecting a policy by welfare agencies to focus on community rather than residential care.

ii. Child minding on a daily basis, is, in theory, regulated by the nurseries and Child Minders Regulation Act 1948, amended by the Health Services and Public Health Act 1968. Informal arrangements in which a person uses their private house mainly as a residence, but partly as a place for looking after a child or children on a daily basis, are not regulated. If however a person is using premises mainly for child-minding purposes, then she must become a registered child minder. The premises must be inspected to ensure that they reach appropriate standards and, in theory, but regrettably not in practice, that she is providing adequate substitute care.

iii. Child labour. The employment of children and young people is regulated by the Employment of Women, Young Persons and Children Act (1920) the Employment of Children and Young Person's Act (1983), various education acts, and bye-laws made by different local authorities. No child under 13 is allowed to work. Young people between 13 and 15 years may work for one hour a day after school, and up to 18 hours<sup>weekly</sup> in the holidays. Young people over 15 may work for 2 hours daily after school and up to 35 hours a week during holidays.

5. Social Security. See under benefits (Section 2 (v)).

6. Fostering and Adoption.

Permanent or semi-permanent substitute care for children is regulated mainly by the Adoption Act 1958, the Children's Act 1958, the Children and Young Person's Act 1969 and the Children Act 1975.

Fostering is legally defined as the care and maintenance of a child who is not a relative, guardian or custodian of the child. The legislation lays down the duties of local authorities in relation to foster children, procedures for fostering, and local authority powers to inspect premises and remove children.

For children whose natural parents have no prospect of providing adequate care for them in the future, it is generally agreed that adoption into another family is the most satisfactory procedure. Adoption proceedings must be taken either by a local authority social services department or by a registered adoption agency. Legislation lays down the duties of these agencies in terms of the enquiries they should make of prospective adoptive parents and the legal procedures involving the consent of the natural parents (which, under some special circumstances, may be dispensed with). Once parents have adopted a child they have virtually the same rights and duties as natural parents.

#### 7. Juvenile offenders.

The Children and Young Person's Act 1969 <sup>and the Criminal Justice Act 1982</sup> lays down procedures for when a child is thought to have committed a criminal offence. If a child is thought to have committed an offence, the case must first be proved in a juvenile court. Children under the age of 10 years cannot be charged with an offence. As with non-attendance at school (see 3.1. above,) if a child has committed an offence, either criminal <sup>care</sup> against <sup>e/</sup> or care proceedings <sup>concerning the child</sup> can be taken. In either case a supervision order or reception into care may follow, since the adult courts often redirect cases to the Juvenile court for further consideration.

If criminal proceedings are taken, <sup>in respect of a child</sup> the magistrates can, in addition, take one of a number of other courses of action. The child may be conditionally discharged, the parents or child may be "bound over" with their consent, the child may be fined (up to £50 up to 14 years, up to £200 from 14 to 17 years). The child may be ordered to attend an attendance centre, or (for 14-17 years) a detention centre, or a junior borstal (for those aged over 15 years), or a community service scheme (for those aged over 16 years). Children who are already subject to a care order may be ordered to live in a residential institution for up to 6 months. In exceptional cases any child or young person\*

Over recent years there has been an increasing tendency for young offenders to be provided with 'Intermediate Treatment' involving obligatory attendance during the day or in the evening at centres providing rehabilitative activities and some counselling.

\*over 10 years may be "detained at Her Majesty's pleasure" indefinitely.

8. Handicapped children.

The 1970 Chronically Sick and Disabled Person's Act lays down certain duties of local authorities to monitor the numbers and make special provision for handicapped people, including children, in their areas.

The 1981 Education Act lays down regulations concerning the education of handicapped children, and these are amplified in circular 1/83 (Department of Education and Science). The Act requires local authorities to consider the needs of all children with special educational needs, not just those requiring education not normally available in ordinary schools. It also requires health authorities to notify the Education Department of any pre-school age children with special needs.

After informal assessment in school, and the advice of appropriate professionals has been taken, the Act lays down the formal procedures which have to be taken if the child does require education not normally available in ordinary school. A "statement" has to be made in which the child's special needs are formulated, and which includes any evidence leading to that formulation. Parents are expected to contribute to the statement and are given a copy of it. The Act lays down an appeals procedure as well as arrangements for review and re-assessment of the child's needs.

Section 4

Patterns of Health Care

a. The Department of Health & Social Security (DHSS) is the government department most directly concerned with child mental health matters. Other relevant government-departments include the Department of Education & Science, and the Home Office (responsible for the police and system of justice). There are no national mechanisms for linking government departments, but ad hoc committees etc. are set up for this purpose. Until its abolition in 1981, the Children's Committee (administered by the DHSS) fulfilled this function. A new, independent coordinating body has now been proposed.

b. England and Wales are divided for administrative purposes into 14 health regions, each of which is divided into a number of health districts serving populations in the region of 100,000 to 200,000. Each district has responsibility for hospital and community health services. Hospital services are centred in the district general hospital and usually, but not always, hospital paediatric care is provided in this hospital. Each district is served by a number of general family practitioners whose list of patients is usually between 1500 and 3000 people of whom just under a third are likely to be children under the age of 16 years. Each district also has a community health service, staffed by doctors, nurses, speech therapists etc. which is the responsibility of the district community physician. This provides surveillance services for pre-school children and a school medical service. The surveillance service is shared with general practitioners who provide a significant contribution (see below).

Coordination between health, social service and education departments is possible at district level by the existence of joint consultative committees.

c. Amount and type of health facilities.

Ante-natal care is provided by general practitioners and by obstetric departments in district general hospitals. Some, but not all, obstetric departments provide ante-natal instruction in groups or for individuals.

As already stated, virtually all deliveries take place in NHS hospitals with qualified attendants present. There is a move to make it easier for mothers to have their babies at home, but this is currently opposed both by professional opinion and government policy. Mothers are discharged from hospital after a variable period, usually between two to four days after delivery, but this varies from 6 hours to 6 days. Babies requiring intensive care because of prematurity or other complications are likely to be able to receive some special care at their place of birth, but may require transfer to a more specialised unit. Some, but not all such units have residential accommodation for mothers.

Once the baby has returned home, the health visitor has a statutory duty to visit and check on the health of mother and baby in the first 10 days of the baby's life. Subsequent health checks are carried out at child health clinics that maybe run by the local authority or by the family general practitioner. Surveillance is carried out systematically, and, in younger children, the baby's weight, vision and hearing are routinely checked. Opportunities for discussion of child care vary considerably. The Court Committee (DHSS 1976) recommended that there should be further checks on the baby's health and development at 6 weeks, 7 to 8 months, 18 months, 2½ to 3 years, and 4½ to 5 years.

Primary care for illness is provided by general practitioners and is freely used by parents. On average, preschool children are taken to their doctors 4 to 6 times per year and 5 to 14 year old children 2.1 times (DHSS 1976). In inner cities a significant proportion of non-emergency primary care is provided in accident and emergency departments, though it is generally agreed that this is undesirable.

If more specialist advice or treatment is required, the child is referred to a paediatrician or other specialist at a district general hospital. Children are usually seen and referred back after investigation to their general practitioner with a letter containing information and advice. A proportion of children is admitted, usually to a bed on a children's ward - the total number of available beds in England and Wales were 7,295 in 1975. Childre requiring yet more specialised services are referred for investigation and treatment to tertiary referral services usually existing in a major children's hospital in one of the

large cities. All health regions have a specialist centre of this type.

Accident and emergency care for children is usually provided in the general accident and emergency department of a general hospital, but occasionally in a children's hospital. The provision of "out of hours care" for children with urgent health and social needs has been a matter of concern.

d. Number of professionals in England and Wales.

Information for health professionals is provided in the Health and Personal/Service Statistics for England (DHSS 1982).

Numbers available are as follows:

General medical practitioners 24,359

Total nursing staff in primary health care services 32,747

School nurses 5,382

Consultant paediatricians 498

Paediatric senior registrars (in training) 144

Consultant child and adolescent psychiatrists 295

Child and adolescent psychiatry senior registrars (in training) 83

Paediatric surgeons 40

Paediatric neurologists 7.

Numbers of other relevant professionals include:

Educational psychologists, about 1,100

Clinical psychologists working with children, about 400: many work with adults as well as children.

Teachers in maintained schools for maladjusted 1604 (399 specially qualified)

Teachers in non-maintained schools for maladjusted 169(23 specially qualified).

The number of community social workers working with children is not known, as the majority of social workers carry out "generic" or non-specialised work.

Social workers employed by social services departments

Residential social workers in children's homes

Social workers in community homes (education)

Youth workers.

e. Proportion of children seen by health workers etc.

As already indicated, all babies are seen in their homes by a health visitor in the ten days after birth, and this is a statutory requirement.

A high proportion of children are seen for surveillance by a doctor and/or health visitor in the first year of life, approximately 89% in 1980 (DHSS 1982). A somewhat smaller proportion (approximately 84%) are seen for surveillance in the second year of life. Subsequently the proportion drops, but a significant number are seen for surveillance between two and five years before school entry. Surveillance is provided by clinical medical officers, general medical practitioners and health visitors, some of whom work in child health clinics and others are attached to general practice. Of 360,000 surveillance sessions carried out in 1980, clinical medical officers carried out 55%, general practitioners 13%, and health visitors working alone 31% (DHSS 1982).

The school health service is staffed by school nurses and clinical medical officers with a variety of other health staff, physiotherapists, speech therapists etc. working mainly in special schools. Education welfare officers are frequently attached to secondary schools and social workers mainly to special schools. Although all children receive a health check on school entry, subsequent surveillance is increasingly provided on a selective basis.

f. Voluntary organisations.

i. Health. The role of voluntary organisations is relatively small in the delivery of health care, greater in education and more substantial still in social welfare. Very few health activities are dependent on voluntary activity in any way, although the provision of play staff on children's wards, some additional amenities and hospital transport have benefitted from voluntary activity. There is a large number of parents organisations linked to particular handicaps, acting as pressure groups, but also often taking on an active role in other activities such as the promotion of research and the dissemination of information. Some of these are mentioned in section 10 below. It is the present government's intention that the contribution of voluntary agencies to health care should increase.

ii. Education. Voluntary organisations have played a more prominent part in the develop<sup>ment</sup> of educational services. Such organisations have acted as pressure groups on local authorities to ensure they fulfil their responsibilities and have also often been responsible for the development of new types of schools or other educational ventures. Thus, the National Association for Mental Health (now MIND), set up schools for the maladjusted, and the National Association for Autistic Children has established a considerable number of specialist

schools for the education of children with severe communication disorders over the last 15 years.

iii. Social welfare. There is a long tradition of voluntary activity in the sphere of social welfare dating back to the 19th century. Bodies such as Dr. Barnardo's, and the Church of England Children's Society have provided residential care for orphaned children and those for whom parental care is inadequate. The National Society for the Prevention of Cruelty to Children has been active for many years in service, teaching and research in the field of child abuse.

iv. Coordination of voluntary activity. The National Children's Bureau, itself an outstanding example of a voluntary organisation established to conduct research and disseminate information, was instrumental in the setting up of the Voluntary Council for Handicapped Children, a body enabling some degree of coordination of activities among voluntary bodies.

g. The School Health Services. (See 2(b) and (d) above.

h. Traditional systems of prevention and treatment.

There is no established, alternative traditional system of delivery of health care to children as is the case in many developing countries. Nevertheless, it is very likely that traditional beliefs remain important in child health care in many parts of the country. The use of herbal remedies, and, more especially, cough mixtures, elixirs and tonics of no proven scientific value is widespread.

The role of the clergy has probably diminished over the past few decades, but, for a significant proportion of the population, the local vicar, priest or minister remains an important and consoling figure in times of crisis and ill health.

Often under-rated in the delivery of health care is the local pharmaceutical chemist, whose advice on medication, especially for minor disorders affecting children, may often be as important, if not more important, than that given by the family doctor or health visitor.

Section 5

Rates of Child Mental Health Problems, their types and causes.

A. Emotional and behavioural problems.

It is agreed that psychological disorders in children in general represent deviations from the norm rather than qualitatively distinct phenomena. Therefore the distinction that has to be made between the presence of a significant problem and its absence is necessarily an arbitrary one. In order to obtain a sense of the severity of the disorders whose rates are described in this section, it is necessary to read the case descriptions provided in the studies to which reference will be made.

Overall prevalence.

i. Preschool problems. A study of a total population of 3 year olds in a North London borough suggested that 1% suffered severe, 6% moderate and a further 15% mild problems (Richman et al 1982).

ii. Problems of the middle school years. A comparative study of 10 year olds (Rutter et al 1975) suggested that the overall prevalence of psychological disorder was 25% in an inner London borough and 12% in the Isle of Wight, a semi-rural area with most of the population living in small towns.

iii. Adolescence. A study of 14 year olds living in the Isle of Wight (Rutter et al 1976) suggested a prevalence of 20% of psychological problems in this age group. A roughly similar figure was obtained for 13 to 14 year olds living in a Northern English city (Leslie 1974). There are no satisfactory figures available for rates of disorder in later adolescence.

Prevalence of specific problems.

i. Autism. The rate of childhood autism is 3 to 4 per 10,000 children (Lotter 1966).

ii. Anorexia nervosa. This occurs in 1% of older adolescents attending school (Crisp 1976).

iii. Emotional disorders. These constitute just under half the overall prevalence rate of children in their middle school years and adolescents (Rutter et al 1970).

iv. Conduct disorder. These also constitute just under half of children in their middle school years and adolescents who show significant psychological problems (Rutter et al 1970).

v. Enuresis. At 5 years, 13% of boys and 14% of girls wet their beds at least once a week. At 10 years 9% of boys and 7% of girls, and at 14 years 3% of boys and 2% of girls wet their beds at this frequency (Rutter et al 1973).

vi. Encopresis. At 10 to 12 years, 1.3% of boys and 0.3% of girls are soiling themselves at least once a month (Rutter et al 1970).

vii. Hyperkinesis. The prevalence in the age period of maximum occurrence (3 to 7 years) is unknown, but at 10 to 11 years, hyperkinetic syndrome is rare, occurring in only about 1 per 1000 children (Rutter et al 1970).

#### B. The Stresses Facing Children.

Any description of environmental factors and their influence on the development of psychological problems must mention that stress rarely acts in a uni-causal manner. Most adverse environmental factors are related to each other, and in considering their impact, it is important to be aware of the importance of factors within the child, especially his or her own temperament and coping mechanisms, and the way these interact with stressful circumstances. The following stress factors have been demonstrated to be of importance in the development of emotional and behaviour problems in British children:

i. Family factors. Disturbed relationships within the family, including negative attitudes of parents towards their children. Intra-familial violence. Parental mental illness and personality disorder. Parental separation and divorce. In 1980 there were approximately 10,100 children under the age of 5 years in the care of local authorities, 62,100 aged 5 to 15 years and 23,000 aged 16 years or over (DHSS 1982). These children are at high risk for the development of psychological problems. In 1980 there were 2,600 children in care in England and Wales because they had been abandoned or lost.

ii. School factors. Lack of or poorly formulated education objectives. Emphasis on deterrent and punishment rather than reward. Teacher time-keeping and prompt marking of homework. Failure to share responsibility among pupils.

iii. Physical illness in the child. All chronic physical illnesses are associated with high rates of problems, but this is especially marked with cerebral disorders such as epilepsy and cerebral palsy.

iv. Environmental factors. Overcrowded housing circumstances. Tower block accommodation (for younger children). Inner city environments.

v. Educational failure in the child. Children of very low ability and those of normal intelligence but with specific retardation in reading are especially likely to show psychological disorders.

#### C. Reactions to Stress.

Reactions to stress seen in British children depend especially on the age of the child concerned. Preschool children are likely to show management problems characterised by irritability, temper tantrums, feeding and sleeping problems, withdrawal, shyness and general misery. Children in the middle school years tend to show either conduct problems such as aggressiveness, bullying, truancy, stealing and lying; emotional problems such as depression, anxiety, fearfulness, withdrawal and shyness; or a combination of these. Adolescents react much as do children in their middle school years, but also begin to show adult-type problems such as more clearly defined depressive reactions and anxiety states. Throughout the whole period of childhood and adolescence, children prone to react to stress with physical symptomatology such as asthma, headaches and abdominal pain will tend to show these characteristic somatic responses.

In general, severe reactions to stress are merely exaggerations of those seen in ordinary children, but characterised by greater severity and persistence.

In order to understand the emotional reactions of children from different sub-groups, such as West Indian and Indian migrant children, it is necessary to have a good understanding of the special problems such as racial prejudice and harassment which they face in their lives. There is however no good evidence that the type of problems shown are different in nature, nor that there are any culture based psychiatric syndromes in childhood occurring with any frequency in this country.

#### b. Mental Retardation.

i. Severe mental retardation. Children with IQ below 50 continue to appear at a rate of approximately 3 per 1000 (Laxova 1977). Approximately one-third are due to Down's Syndrome, one-third due to other established causes,

and one third are of unknown origin. Of known causes other than Down's Syndrome, single-gene conditions (dominant, recessive or X-linked) account for 15% of the total, environmental factors (including maternal infection, post-natal injury and infection) account for 5% and multi-factorial causes (e.g. developmental anomalies with trauma) account for a further 12%.

ii. Mild mental retardation (I.Q. 50-70), occurs in approximately 2.5% of the population and is due largely to multi-factorial influences especially social disadvantage, but including polygenic inheritance. Children with this level of intelligence are likely in the U.K. to come from large, lower social class families living in poor housing circumstances (Rutter et al 1970).

c. Learning difficulties.

Children of normal ability with specific learning problems are common in the U.K. Using a criterion of 2 standard deviations (or approximately 2 years retarded) below expected reading age, specific reading retardation has been found to occur in about 10% of inner London children and about 3% of Isle of Wight 10 year olds (Berger et al 1975). The causes are probably multi-factorial and include especially poor early home stimulation, inadequate teaching, lack of home-school cooperation and genetic factors.

d. Epilepsy

Febrile convulsions, which are usually, though not always of transient significance, and are partly genetically determined, occur in about 5% of children.

The prevalence of epilepsy has been established as between 4 and 8 per 1000 children (Ross et al 1980, Rutter et al 1970), depending on the degree of substantiation required for the diagnosis to be made.

In the Isle of Wight study, almost exactly three-quarters of a total population of <sup>to 14</sup> 5 year old children with epilepsy had no other evidence for brain damage or dysfunction, and, in the other quarter, the fits were associated with cerebral palsy or other evidence of structural brain disorder (Rutter et al 1970b). In three-quarters therefore the aetiology is unknown. Of the causes of epilepsy associated

with cerebral disorder, developmental anomalies, abnormalities of birth and post-natal conditions such as infantile spasms are of greatest importance.

Section 6

Delivery of Mental Health Services to Children

- i. Most mental health problems of mild or moderate severity are not seen, assessed or treated by trained professionals in the health, education or social welfare services. This is especially true for emotional and behaviour problems, mild mental retardation, and mild and moderate specific learning difficulties (Rutter et al 1970). Probably virtually all cases of epilepsy are seen by medical practitioners.
  
- ii. First line assessment and treatment for different types of mental health problems is mainly provided by general practitioners, teachers in ordinary schools and social workers. Thus, for example, Bailey et al (1978) showed that in a quarter of child consultations with G.P.s a psychological component to the presenting problem existed. It is probable that children who are <sup>known</sup> to social workers also show at least as high rates of mental health problems. The system of child health surveillance described in section 4 above provides an opportunity for first line assessment. This is likely to be effective in relation to physical problems including sensory deficits and severe developmental delays, but less so in relation to other mental health problems.
  
- iii. More specialist care for children with mental health problems is provided in a variety of ways which vary depending on the nature of the difficulty.
  - a. Emotional and behaviour problems.

These are likely to be identified by parents or teachers. From home the child is likely to be referred to a general practitioner who, if the problem is severe, will refer to a child and family psychiatric clinic either in the community or functioning as a hospital department. Such clinics are staffed by a multi-disciplinary team consisting of psychiatrists, psychologists, social worker and (in the London area) psychotherapist. From school the child is likely to be referred to an educational psychology service. In some areas this service will be part of a multi-disciplinary team, in others it may link to hospital service.

Children with severe problems may be admitted to a psychiatric day centre or to an in-patient unit. In 1974 there were 65 in-patient units specifically available for the treatment of approximately 1088 pre-adolescent children, adolescents of school age and older adolescents (DHSS 1976).

There is a wide range of special educational provision for children with emotional and behaviour problems, including tutorial classes, units for disruptive children, special day and residential schools for maladjusted children, and day and residential schools for autistic children. There were, for example, in 1982, 199 maintained and 20 non-maintained schools for maladjusted children in England and Wales. Children are referred for special educational provisions after assessment by educational psychologists and, in many instances, by social workers and psychiatrists.

There is also a range of social welfare provision for children with emotional and <sup>behaviour</sup> problems, especially intermediate treatment centres (see above) and CHES or Community Homes <sup>with</sup> education. Attendance at these facilities usually follows either criminal or care proceedings in a juvenile court (see section 3).

b. Specific learning difficulties.

Severe retardation in reading ability in children of normal intelligence is usually provided for in part-time remedial classes in ordinary schools. However some local education authorities run separate remedial education units which children usually attend on a part-time basis.

c. Mental retardation.

Children with severe retardation (I.Q. less than 50) virtually always receive special education in a school for the educationally subnormal (severe) - ESN (S). A minority attend such schools on a residential basis. Following the passage of the Education (Handicapped Children) Act 1970, all such children are retained within the education system and receive instruction from teachers, no matter how profoundly retarded they may be.

Children with mild or moderate degrees of mental retardation (IQ 50 to 70) usually attend special schools for the moderately educationally subnormal (ESN(M)), especially if they are at the lower end of the IQ range and/or if they have associated social disadvantages or health problems. A considerable number of children at the upper end of this ability range are in ordinary schools, usually in the lower streams or in remedial or "opportunity" classes.

d. Epilepsy.

Nearly all children with epilepsy are seen by their general practitioner and most are referred to hospital paediatric departments for initial investigations and treatment. Assuming the epilepsy is not symptomatic of an underlying treatable medical condition, subsequent management is undertaken either by the general practitioner or hospital paediatrician.

If the epilepsy is severe and intractable to treatment, the child may be placed in a special school for physically handicapped children. There are, in addition, three residential schools or hospital schools specialising in the residential care of children with epilepsy. There is a National centre for the assessment and management of children with epilepsy at the Park Hospital, Oxford.

Methods of Prevention and Treatment.

These are difficult to summarise, but the following is a brief outline.

i. Emotional and behaviour problems. Most centres are family-orientated, and combine a psycho-dynamic approach with the use of behavioural methods in selected cases. Medication is little used, and is reserved for the treatment of severe hyperactivity, "endogenous" depression, adult-type psychotic disorders, and, occasionally, nocturnal enuresis.

ii. Learning difficulties and mental retardation. Whether or not health professionals are involved in assessment, treatment or remediation is likely to depend almost entirely on the use of special educational methods.

iii. Epilepsy. Recurrent epileptic attacks are treated with a variety of types of anti-convulsant medication. A very small number of selected cases are treated surgically.

A number of evaluative studies of treatment have been carried out and these have established the efficacy of some school-based counselling and group work, the bell and pad in the treatment of bed-wetting, structured educational methods for autistic children, family therapy for asthmatic children. Evidence for the efficacy of stimulant medication for hyperactivity and short-term psychotherapy for emotional disorders is

available from studies carried out in North America..

## Training

### Non Child Mental-Health Professionals.

Most non-mental health professionals dealing with children receive inadequate instruction in the psychological aspects of child development and family life, even though much of their time is taken up in dealing with problems in this field. There is little systematic information on the quantity of instruction given on a national basis, and only a little more from curricula of particular courses. The following however is thought to be relevant information:-

1. Medical students. Most medical students receive instruction in child psychiatry either during their attachment to paediatrics or psychiatry or both. A <sup>national</sup> survey of child psychiatry instruction for medical undergraduates was carried out in 1977 by the senior lecturers in child psychiatry in London. The position has probably not changed much since then. Medical schools offered on average about 8 half days in all, and the maximum offered was 8 full days.
2. Paediatrics. Training in child psychiatry is regarded by the British Paediatric Association as desirable for paediatricians, but in fact, it is only rarely provided. As far as we know, only the Hospital for Sick Children, Great Ormond Street, has a regular rotation for paediatricians through child psychiatry, and even there, by no means all senior registrars obtain this experience.
3. General Psychiatrists. It is the policy of the Royal College of Psychiatrists that all general trainees should spend time in a child psychiatry placement. In fact, only a minority do so, though there has been a definite increase in the proportion obtaining this experience over the past five years.
4. Paediatric nurses. Child development and psychological disorders of childhood are prominent in the curricula of paediatric nurses. No information is available on the precise amount provided on different courses.
5. Teachers. There is no national information on the amount of teaching on psychological problems, though this is now being collected. At the Institute of Education, about one in four of the secondary school teachers-in-

training do a Psychology Foundation Course consisting of 4 lectures. About half the students attend a series of 17 workshops on the identification of special needs with emphasis on learning and behaviour difficulties. A minority of secondary school teacher students obtain special experience in some remedial work. Primary students have four lectures on various physical, sensory and learning difficulties, and two sessions on reading difficulties.

6. Social workers. Social work trainees receive a variable number of lectures in child development and child psychological problems. A number will have had pre-course experience in residential care settings for children and in other child care situations. A number will also experienced a specialised placement in work related to children, such as child guidance clinic or assessment centre during their course.

Section 8

Special Developments and New Programmes

It is an invidious task to pick out special developments in England and Wales of special relevance to child mental health, but the following would appear to those who have prepared the study to be worthy of special note.

i. The National Children's Bureau was founded over 20 years ago under the directorship of the late Dr. Kellmer Pringle. This independent organisation has acted as a focus for voluntary activity relating to many different aspects of child care, and has pressed for progressive legislation. It has been responsible for the conduct of one of the three National cohort studies which have provided a mass of information of relevance to service planners.

ii. The Department of Child Psychiatry at the Institute of Psychiatry, London, directed by Professor Michael Rutter, has conducted a wide variety of research investigations. These have included epidemiological studies into the incidence and prevalence of child mental health problems and the overlap between them, studies of the ways in which school factors influence child behaviour and studies of the effects of an institutional upbringing on later behaviour.

iii. The Hester Adrian Research Centre, University of Manchester, until now under the direction of Professor Peter Mittler, has for some years conducted research into the development of mentally handicapped children and the ways in which this can be enhanced. The Centre has also been particularly active in promoting improvements in the training of teachers of the mentally handicapped.

The names of organisations, both governmental and independent, of particular relevance to child mental health are provided in section 10 below.

As far as the authors of this report know, there are no special programmes or projects currently being undertaken under the auspices of WHO, UNICEF or other international agency.

Section 9

Suggestions for Action

There are many fields of action in which the injection of additional resources would act to the benefit of children and promote their mental health. The following is a list of possible activities which seem to the authors of this study to be of special relevance. None of them is particularly novel - all have been suggested by many others working in the field: -

- i) The establishment of family courts, especially to deal with problems relating to the custody of children of divorcing parents. The present adversarial approach is detrimental to the welfare of children. An extension of the few existing divorce conciliation services would also be /help
- ii) Research into the effectiveness of special schooling for children with emotional and behaviour problems. All forms of special education are particularly poorly evaluated at the present time.
- iii) Study of good practice in child mental health facilities. There is a considerable amount of confusion over the appropriate roles and functions of different mental health professionals. Some clinics and departments have however established good working relationships and effective working methods. There is a need to disseminate information concerning their organisation and practice.
- iv) The management of severely disturbed adolescents causes major problems. There is a need to identify appropriate methods of working and facilities to deal both with psychotic and severely aggressive teenagers.
- v) Most mental health problems are not seen by mental health professionals, but by primary workers. There is a need to test the feasibility of establishing reasonably brief methods of assessment and treatment of emotional and behaviour problems by health visitors, general practitioners, teachers in ordinary schools and social workers.

The authors of this report are uncertain to what degree it would be possible for WHO and other international agencies to assist in these various developments. They suspect that resources will have to be found nationally if progress is to be made.

Relevant Agencies and Organizations

The following list is certainly incomplete, but seen to the authors of this study to contain most of those particularly relevant to the field of child mental health.

A. Government Departments.

Department of Health and Social Security, Alexander Fleming House,  
Elephant and Castle, London, SE1 Tel: 01 407 5522

Department of Education and Science, Elizabeth House, York Road, London, SE1  
Tel: 01 928 0222

Office of Population Censuses and Surveys, 10 Kingsway, London, WC2  
Tel: 01 242 0262

B. National Associations - General.

Association for Child Psychology, Psychiatry and Allied Professions,  
4 Southampton Row, London, WC1 Tel: 01 405 0351

National Children's Bureau, 8 Wakley Street, London, EC1. Tel: 01 278 9411

MIND, 22 Harley Street, London, W1 Tel: 01 637 0741

Family Policy Studies Centre, 3 Park Road, London, NW1 6XN Tel: 01 436 8211

Child Poverty Action Group, 1 Macklin Street, London, WC2 Tel: 01 242 3225

National Council for One Parent Families, 255 Kentish Town Road, London NW5  
Tel: 01 267 1361

National Council for Voluntary Organizations, 26 Bedford Square, London WC1  
Tel: 01 636 4066

C. National Associations for Special Mental Health Problems

Royal Society for Mentally Handicapped Children, (MENCAP), 123 Golden Lane,  
London, EC1 Tel: 253 9433

British Epilepsy Association, New Wokingham Road, Wokingham, Surrey.  
Tel: Crowthorne 3122

Spastics Society, 12 Park Crescent, London, W1 Tel: 01 636 5020

National Society for Autistic Children, 1a Golders Green Road, London, NW11  
Tel: 01 458 4375

British Dyslexic Association, 4 Hobart Place, London, SW1 Tel: 01 235 8111

D. National Professional Organizations

British Association for Social Workers, 16 Kent Street, Birmingham 5 Tel: 021 622

Association of Child Psychotherapists, Burgh House, New End Square, London, NW3  
Tel: 01 794 8881

Royal College of Psychiatrists (Child & Adolescent Psychiatry Section)  
17 Belgrave Square, London, SW1 Tel: 01 235 2351

British Psychological Society, St. Andrews House, 48 Princess Road East, Leicester.

Recent publications and journals of special relevance to child mental health problems.

Department of Health and Social Security (1976) A report on child health services - the Court Report, HMSO, London.

Department of Education and Science (1978) Report of the Committee of Enquiry into the Education of Handicapped Children and Young People - the Warnock Report, HMSO, London

Journal of Child Psychology and Psychiatry

Bulletin of the Association for Child Psychology, Psychiatry, & Allied Professions.

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