In the 1970s, the World Health Organization defined health as ‘a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (Breslow, 1972). This emphasis on total wellbeing—and not simply on the presence or absence of disease—is at the foundation of an increasing emphasis on child mental health promotion and mental illness prevention (Kvalsig et al, 2014).

It is the critical development of social and emotional skills during the early years of life that provides the foundation for life-long mental health. With support from families, communities and professionals, children can build strong skills and achieve their full potential.

Globally, the burden of mental health problems among children is significant, with some studies estimating they affect one in five children (e.g. Belfer, 2008). In Australia, one in seven children between 4 and 11 years is thought to have a mental health disorder (KidsMatter, 2015). However, in the years before the age of 4, there is no population-level data that can provide an indication of children’s social and emotional development.

When families have concerns about their child’s poor social and emotional development in the early years, it is often a child and family health nurse or GP who is the first point of call. The years from 2000 to 2013 saw a significant increase in the rate of ‘all psychological problems’ seen by Australian GPs among children between 6 and 11 years (Pollack, Harrison, Charles & Britt, 2014).
The National Health Survey of Australians, conducted in 2014, showed that around half of families seek help when they have concerns about their child’s mental wellbeing (Australian Bureau of Statistics, 2015). This emphasises the need for frontline service providers to be equipped to help families to support their child to achieve that ‘state of complete physical, mental and social wellbeing’, and for those professionals to maintain an up-to-date network of specialist providers so as to enable children and their families to be referred when appropriate.

**Child mental health is on a dual continuum**

Research into adult and adolescent mental health has shown that for these older age brackets, mental health exists on a dual continuum (eg: Keyes, 2007; Suldo & Shaffer, 2008). If mental health and mental illness existed on a single continuum, then high mental health competency would always correlate with good mental health and vice versa. A dual continuum model shows that it is possible to have high mental health competency but poor mental health, and poor mental health competency but good mental health.

In the early years, mental health competency encompasses access to education; a sense of belonging and connectedness; and the development of social and emotional skills (Victorian Department of Education & Early Childhood Development, 2008). Research from the 2012 Australian Early Development Index (AEDI) (now Australian Early Development Census) has shown that this dual continuum for mental health can be seen in children in their first year of full-time school (Goldfeld, Kvalsig, O’Connor et al, 2015). The data showing that mental health and mental health competency are distinct elements emphasises the need to not only to be alert to mental health difficulty but also to promote mental health competency.

The Australian Early Development Census (AEDC) collects data every three years on Australian children who are in their first year of full-time schooling. It is distinct in that one of the areas in which it gathers data is children’s mental health competence, examining this area through the social competence domain.

<table>
<thead>
<tr>
<th>The AEDC asks whether each child:</th>
<th>These questions reflect children’s mental health competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plays and works cooperatively with other children</td>
<td>Is eager to play a new game</td>
</tr>
<tr>
<td>Demonstrates self control</td>
<td>Comforts a child who is upset</td>
</tr>
<tr>
<td>Can solve problems by him or herself</td>
<td>Is anxious or fearful</td>
</tr>
<tr>
<td>Displays aggressive behaviour</td>
<td>These questions reflect possible internalising difficulties</td>
</tr>
<tr>
<td>Displays hyperactivity and inattention</td>
<td>These questions reflect possible externalising difficulties</td>
</tr>
</tbody>
</table>

(Goldfeld, Kvalsig, O’Connor et al, 2015).

The AEDC results showed, as would be expected, that for most children, high mental health competence was associated with low mental health difficulty, and poor mental health competence was associated with high mental health difficulty (Goldfeld, Kvalsig, O’Connor et al, 2015b). However there were small groups of children who displayed ‘off diagonal’ results, demonstrating either high mental health competence and high mental health difficulties, or low mental health competence and low mental health difficulties.

These results indicate that high mental health competence in children does not always guarantee the absence of mental health difficulties. Conversely, low mental health competence is not always associated with high mental health difficulty. The data indicate that there are other factors involved in why children display mental health difficulties.
Protective factors

In the preschool and early years, there are a number of factors that are within the child that act as protective factors for mental health, and increase children’s mental health competence:

- having an easy-going temperament
- having positive expectations of themselves
- feeling positive about the future
- having a sense of independence
- possessing good communication, problem-solving and social skills
- being able to regulate their own emotions
- positive, lasting relationships with friends and family. (KidsMatter, 2012).

These factors reflect many of the key developmental tasks of the early years, which are supported by good attachment and a supportive, buttressing family environment.

Risk factors

In toddlers and preschoolers, risk factors for mental health difficulty can be divided into three categories: those within the child, those within the child’s immediate family and environment, and specific life events:

Child:
- is anxious
- withdraws from or avoids new situations
- is irritable or aggressive
- is unable to follow rules or instructions
- displays difficult to manage behaviour
- lacks comprehension of consequences for actions
- has difficulty understanding or using new language.

Family and environment:
- family conflict
- unsupportive or neglectful relationships
- harsh or inconsistent parenting
- a lack of adult supervision
- family separation
- forced migration to a new state or country
- cultural and social isolation
- being affected by a natural disaster
- financial difficulties in the family.

Specific events:
- death or illness of a family member, friend or pet
- separation of parents or carers
- moving house or changing preschool
- losing a friendship
- moving to a new country
- being affected by a natural disaster
- being diagnosed with a disability or serious illness. (KidsMatter, 2012).

Disadvantage and poor child mental health

The 2012 AEDI data showed a clear association between children who come from the most disadvantaged areas of Australia, and children with low mental health competence and high mental health difficulty.

Figure 2 The relationship between the dual continuum of mental health and socioeconomic data
2012 AEDI data in Goldfeld, Kvalsig, O’Connor et al, 2015b.

This graph does not include information for children with moderate levels of mental health competence.

The data indicate that children who live in the most disadvantaged communities have twice the risk of being among the group of most vulnerable children in terms of their mental health. This finding correlates with existing evidence showing that mental health competence increased in line with socioeconomic advantage (Drukker et al, 2003; Brody et al, 2002; O’Connor et al, 2012). These data also indicate that more intensive support is required for children who live in disadvantaged families in order to address inequities in the prevention of mental health difficulty and to promote good mental health.
Family conflict and poor child mental health

Family conflict, and possible accompanying factors such as separation of parents, is also a risk factor for child mental health difficulties.

The Maternal Health Study recruited 1,507 Melbourne women who were pregnant with their first child in order to develop a comprehensive picture of women’s health during pregnancy and after their first birth (Brown, Gartland, Woolhouse et al., 2015). Participants were followed up early in their pregnancy and at child age 3, 6, 12, 18 and 48 months.

The Study found that family violence rates were high — 20 per cent of women experienced emotional and/or physical abuse at the hands of an intimate partner in the first 12 months after birth (Brown, Gartland, Woolhouse et al., 2015). When the question included any experience of family violence between the child’s birth and fourth birthday, 29 per cent of surveyed women had experienced family violence (Gartland, Woolhouse, Mensah et al., 2014).

For babies and children, the health consequences were significant. Babies born to mothers experiencing family violence were twice as likely to be born at a low birthweight (under 2500 grams), meaning that they would be at a higher risk for diabetes and hypertension across their lives than babies who were in the normal weight range at birth (Brown, Gartland, Woolhouse et al., 2015). Children whose mothers experienced family violence in the first year of the child’s life were more likely to have emotional and/or behavioural difficulties at 4 years old (Brown, Gartland, Woolhouse et al., 2015). Those children whose mothers reported family violence in their baby’s first year, as well as when that child was 4 years old, were more likely to be experiencing mental health difficulties at that age (Gartland, Woolhouse, Mensah et al., 2014).

Family violence has significant and long-term effects for mothers and for children. Adding to the complexity is that family violence prevalence has been shown to be higher in socially disadvantaged populations, meaning that financial difficulty and housing problems — additional risk factors for child mental health difficulty — are also often present. The Maternal Health Study team note that ‘service responses and care pathways need to be developed giving consideration to the constellation of risk and vulnerability that often surrounds women’s experience of family violence’ (Brown, Gartland, Woolhouse et al., 2015).

Promoting mental health competence

As a universal service, child and family health nursing is in a unique position to help families to promote their child’s mental health competence through the early years and to be alert to those children whose life experiences may be putting them at a greater risk. Developing and maintaining strong links between health services and community, housing and legal services will facilitate appropriate and timely referral for children and families who are in need of additional help.

These links, in addition to effective partnerships with colleagues and clients, will help to facilitate a coordinated and sensitive response that supports all children.

References

Bridging the gap: talking about child mental health and wellbeing

Professionals who work with young children and their families need a way to constructively engage with families about child mental health.

One of the challenges associated with talking about child mental health with families is the strong beliefs that many people hold, whether consciously or unconsciously, about mental health. When it comes to children there is a pervasive idea that children simply ‘cannot have’ mental health issues (Kendall-Taylor & Mikulak, 2009; Kendall-Taylor, 2010).

An additional challenge is that when the topic of mental health is raised, many people default to thinking of mental illness. When talking about children, this can lead to thinking about medication, which can be frightening for some parents.

Strategic framing

Strategic framing is a tool that can help health professionals have more constructive conversations with families about complex topics like child mental health.

In our daily conversations there are many different influences at play. The beliefs, assumptions and values developed over a lifetime provide us with a framework for understanding the world. These familiar frames are the sum of our prior experiences, exposures, emotions and other stimuli. They shape the way we interpret new information, and interact to influence the way that we think about an issue or idea.

Research shows that humans are fast and frugal thinkers, but that efficiency can come at a cost because our default models can be wrong or lack sufficient understanding. When you have a conversation about child mental health with families, their familiar frames act to shape and influence the way they understand the information that you share. This interaction can help or hinder families’ ability to consider information on early childhood development in a clear and objective way. That is, the evidence-based information that you’re sharing could inadvertently activate an unhelpful familiar frame.

By speaking to families in a way that is strategically framed and uses metaphors for complex topics, metaphors that have been demonstrated to build understanding, you can help to avoid tapping into unhelpful frames. You can also activate the sort of thinking that is useful in empowering families to see what they can do to promote their child’s mental health.

Mapping the gaps

To help to learn more about how to communicate effectively about child development and the importance of the early years, the Centre for Community Child Health has worked with the FrameWorks Institute.

FrameWorks is a US organisation that works with non-profits to enhance their communication efforts. Their research contributed to understanding more about what Australians’ familiar frames are when it comes to early childhood, and how we can use strategic framing to bridge the gap between what experts in child health and development know, and what the public understands.

When it comes to child mental health, some of the obstacles you may need to overcome include:

Discussions of mental health become discussions of mental health problems

The distinction between mental health and mental illness is easily blurred. Research has shown that when child mental health is the conversation topic both child mental health experts and members of the general population readily move the discussion into one about mental health problems (Kendall-Taylor, 2010). This switch to thinking about problems can potentially distract from conversations about mental health promotion.

A parent-led interview style has been shown to be most effective when seeking to engage parents on complex family psycho-social issues in a child and family health setting (Kearney, Cooper, Hallaron et al, 2014). Importantly, this style of interview has been shown to be acceptable for both parents and nurses. In addition to interview style, the language used to discuss child mental health and wellbeing can be a critical factor in discussions with parents and families.

Poor mental health may be seen as fixed and resistant to influence

Child mental health can be divided into two categories by a general population — positive child mental health is seen as analogous to emotional regulation and a learned behaviour, while mental illness can be seen as fixed and immutable, a product of the child’s genetic makeup that cannot be altered (O’Neil, 2010). These binary understandings of child mental health — either fixed, or about emotions — can pose a barrier to understanding and considering strategies to address mental health issues or promote child mental health.
Ageing up
A challenge of discussions about child mental health is that they are often affected by ‘ageing up’, where a conversation that the professional has instigated about a 3 year old, becomes one about later childhood or early adolescence. You can see this tendency to age up very quickly in the first couple of minutes of this video, which is asking ordinary Australians about their thoughts on what young children need: https://vimeo.com/90568444 [FrameWorks Institute, 2014]

The tendency to age up reflects that the early years are often seen as a happy time free of problems and the belief that any stressful episodes is not something that children will remember.

Bridging the gaps
Having identified the familiar frames that can derail attempts to speak constructively with families about promoting their child’s mental health, the next step is to apply strategies to keep those discussions on track and build understanding of children’s mental health.

The following metaphors are helpful tools for those who work in the early years to use in conversations with families about child development to promote child mental health. The metaphors can allow you to explain complex topics in an accessible way and help families to understand mental health issues better.

Levelness
Levelness acts as a metaphor for child mental health. As we all know, a functional table is a level one, a wobbly table needs to be fixed. Wobbliness in a table can also come from either the floor — external risk factors — or the table itself, internal risk factors. This offers an opportunity to discuss features within the child or within the child’s environment that could be cause for concern.

With the Levelness metaphor, child health professionals can avoid the thinking that says that mental health problems are fixed and immovable, and that children will ‘grow out of it’ — wobbly tables don’t fix themselves.

Three Types of Stress
The Three Types of Stress — positive, tolerable and toxic — can help in a discussion of risk factors. Short periods of low-level stress, or positive stress, are normal and healthy parts of children’s development. Tolerable stress may be more severe and longer-lasting, but with support from stable and responsive adults, children are able to manage. The third type of stress, toxic stress, is ongoing and children generally do not have stable and responsive adult relationships to buffer the effect.

The Three Types of Stress metaphor allows discussion about the role that responsive parenting plays in helping children to manage tough times, and to suppress the idea that child mental health is fixed.

Toxic stress
“There are three main kinds of stress that children can experience — there’s positive stress, tolerable stress and toxic stress. Positive stress is the types of challenges that can actually help children develop — like facing a challenging social situation or preparing for a difficult test. Tolerable stress is things that could damage development, but that are buffered by having positive relationships — like having strong family support when a loved one dies. And then there is Toxic stress. Toxic stress happens when a child experiences severe and ongoing stress — like extreme poverty, abuse or community violence — without having the benefit of consistent supportive relationships. Toxic stress affects the way that the brain and body develop, and can lead to lifelong problems in learning, behaviour, and both physical and mental health.”

(Nall Bales & Kendall-Taylor, 2014)

The Outcomes Scale
The metaphor of the Outcomes Scale has been developed especially for an Australian audience. Talking with parents about loading up the positive side of the scale offers an opportunity to introduce the high levels of brain plasticity that are a feature of the early years and the opportunity for children to lay the foundation for a lifetime of wellbeing.

With the Outcomes Scale metaphor, child health professionals can introduce a range of factors that promote mental health for children — healthy food, physical activity, reading and storytelling — and offer families concrete ideas for supporting their child’s early development and loading up the positive side of the scale. The metaphor also offers an opportunity to address the need to reduce the number of factors on the negative side of the scale.

(Nall Bales & Kendall-Taylor, 2014)
Outcomes scale

“Think of a child’s development as a scale. The way the scale is tipping is like the outcome of the child’s development. Positive things like supportive relationships get loaded on one side, and negative things like abuse, neglect or community violence and lack of resources get stacked on the other. The goal of every community is to have as many children as possible tipped towards the positive side. To do this, we can offload as much weight as possible from the negative side and we can stack as many factors on the positive side as we can. This is called stacking the scale. We also know that we can give kids support early to help them develop coping skills — these skills push the rocking point over to one side and make the scale harder to tip negative, and able to bear more negative weight and still tip positive. This is what resilience is.”

(Nall Bales & Kendall-Taylor, 2014)

With an awareness of Australians’ familiar frames about child development and child mental health, and a set of powerful and tested metaphors to help explain the science, child health professionals can work with families to help all children achieve the best possible start in life.

References


About the Centre for Community Child Health

The Royal Children’s Hospital Centre for Community Child Health (CCCH) has been at the forefront of Australian research into early childhood development and behaviour since 1994.

The CCCH conducts research into the many conditions and common problems faced by children that are either preventable or can be improved if recognised and managed early.

Community Paediatric Review

Community Paediatric Review supports health professionals in caring for children and their families through the provision of evidence-based information on current health issues.

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