

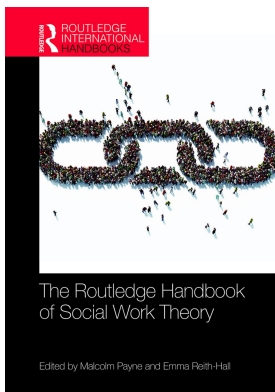
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# Child and adolescent mental health

## A psychosocial perspective

*Emma Reith-Hall*

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### **Introduction**

There is no consensus about what children's mental health actually means (Strong & Sesma-Vazquez, 2015). Even within the field of child and adolescent mental health (CAMH), mental health difficulties encompass a broad range of problems and are conceptualized in different ways. In spite of this confusion, it is estimated that between one in five and one in ten children and young people worldwide experience mental health problems, and it is generally accepted that approximately half of mental health problems experienced in adulthood have their origins in childhood. The impact on children's development, relationships, educational attainment and the potential to live productive and fulfilling lives means that child and adolescent mental health is not an issue we can afford to ignore. CAMH is increasingly being recognized as a global public health concern yet knowledge of how best to understand and support this client group is limited. Social work theories are under-utilized, reflecting the neglected role of social workers within CAMH practice, literature and research. Yet calls for 'high integrity' mental health services for children (Wolpert, Vostanis, Martin, Munk, & Norman, 2017) will open up opportunities for transforming current provision. After considering some key issues in CAMH practice, this chapter explores how a psychosocial perspective can help social workers and allied professionals support the mental health and well-being of children and young people worldwide.

### **The biomedical approach**

Much CAMH literature and research is dominated by the taken-for-granted biomedical approach (see Chapter 6). The various classification systems used throughout the world identify symptoms and levels of impairment to categorize mental health problems into psychiatric disorders. In child and adolescent mental health, these include developmental disorders, internalizing (emotional) disorders, externalizing (behavioural) disorders and psychotic disorders. Through the diagnostic process, the thoughts, feelings and behaviours of children and young people become framed through this biomedical discourse whereby mental health difficulty is conceptualized in terms of pathology or illness.

For some children, young people and their families, a biomedical approach is a helpful way of understanding mental health problems, opening doors to life-changing treatments. Yet for others, the construct of children's 'mental illness' is problematic. Young people have objected to the medicalizing of emotional difficulties (Plaistow et al., 2014) and report having their experiences invalidated (Harper, Dickson, & Bramwell, 2013). Children and young people's thoughts, feelings and behaviours may have interpretable subjective meaning, requiring opportunities for sense-making; hence many young people would prefer to receive psychotherapy (Bradley, McGrath, Brannen, & Bagnell, 2010) or simply talk to someone, rather than be 'fobbed off' with medication (Plaistow et al., 2014).

The diagnostic process itself is also problematic. Current psychiatric diagnoses 'do not capture the complex variety of difficulties that most children and adolescents present' (Wilson, 2016, p. 6); hence some practitioners have indicated that classifying disorders has limited use, particularly given the high degree of co-morbidity found in clinical practice. Young people have reported frustrations around having to meet tightly defined criteria to access services (Smith & Leon, 2001), supporting Timimi's (2016, p. 27) view that 'psychiatric diagnosis does not provide a rational basis for organizing and delivering mental health services'. There can be consequences, too, for those children and young people who do receive a formal diagnosis. A focus on illness and deficits detracts from the strengths, interest, talents and resources that children, young people and families hold, impacting negatively on identity, self-esteem and self-efficacy. The stigmatizing and 'othering' effects of the diagnostic labelling process experienced by users of adult mental health services are also evident in child and adolescent mental health services (CAMHS). The 'us and them' dynamic identified in Harper et al.'s (2013) research found young people felt powerless and blamed for their mental health problems.

When applied to a CAMH context, the 'unhelpful tendency to individualise issues, with a primary focus on [the] internal mental "pathology" of one person' (Tew, 2011, p. 76), locates the problem within the child or young person. Difficulties operating within a family system can produce emotional and behavioural responses that become reframed as a psychiatric disorder identified within the child. Assessment, diagnosis and some of the treatments that stem from these processes can be experienced as mystifying, pathologizing, blaming and shaming to those subjected to them, actually exacerbating the child or young person's presenting difficulty. A strictly biomedical approach to CAMH also ignores the influence of the social world. Focusing on individuals' symptoms fails to account for the socially unjust circumstances in which mental distress arises. The role of poverty and social disadvantage was articulated by Ferguson (Chapter 27) and the influence of social determinants on children's mental health acknowledged by Manion (Chapter 33). Children and young people are situated in families, schools, communities and societies – systems which impact on the development and continuity of good mental health or, conversely, mental health difficulty.

### ***Limitations of the current evidence base***

It is often assumed that pharmacological and psychological answers exist for the wide range of mental health problems experienced by children and young people. Whilst there are some medications and therapies that have repeatedly been evaluated as effective, overall the evidence base for CAMH is surprisingly weak. Concerns have been raised about the research methodology used for acquiring the current evidence base. Randomized controlled trials (RCTs) can demonstrate the effectiveness (or not) of drug treatments, but their utility in establishing the impact of psychotherapy is questionable since, by design, they factor out contextual variables (e.g. a child's motivation or known family stressors), which impact on outcomes in practice. Moreover, some

interventions are disadvantaged by the prevailing positivist research methodologies: strengths-based approaches do not align to treating psychiatric symptoms because attending to problems and deficits is not in keeping with the underpinning philosophy, whilst in psychodynamic therapy, change arises through relational processes rather than specific measurable techniques.

We need to acknowledge the limits of the existing evidence base and consider the extent to which even widely researched interventions actually work. Explicit acknowledgement of this would allow practitioners to instigate more honest conversations about what might help and consider what to do if no improvement is made (Wolpert et al., 2017). This would lower unrealistic expectations that the wide range of increasingly complex problems encountered in practice can be ‘fixed’. As we continue searching for effective strategies and interventions, utilizing a wide range of theories and research methodologies will help open up the process of knowledge creation for this important area of practice.

### ***Lessons from adult mental health***

In adult mental health, user or survivor movements ‘have rejected the notion that there is an objective, value-free continuum that moves clearly through a symptom – diagnosis – treatment – cure – continuum’ (Fawcett, 2004, p. 201). Instead, those with lived experience and their supporters have been instrumental in bringing about change in the way that mental distress and madness are defined, understood and researched and the ways that helping and coping are explored (see Chapter 38). In the UK, ‘social approaches’ to understanding adult mental health are beginning to claim their rightful place in the practice and policy arenas. No parallel movement exists within CAMH; hence, practitioners, advocates and researchers will need to work with children and young people in age-appropriate ways to undertake research and build theories that take account of child and adolescent viewpoints.

### **A psychosocial perspective**

A psychosocial perspective, encompassing a range of theories, can extend our understanding of child and adolescent mental health. Psychosocial practice takes place at the intersection of the individual’s psychological/internal world and subjective states and their social/external world and objective statuses (Megele, 2015, p. 3). Advocating for the use of a psychosocial model in CAMH practice, Walker (2011, p. 18) suggests including the original characteristics of a psychosocial perspective:

Understanding the person as well as the problems they are presenting; recognising the inner psychological experience of the individual and the external social world, which may be in conflict; and actively making use of the service user’s relationship with the social worker.

In addition, Walker (2011, p. 18) suggests that a contemporary psychosocial model requires refinement to ensure that ‘practitioners adopt a holistic perspective and employ personal relationship skills to work in partnership with families and engage with other professionals through culturally competent, community orientated practice’.

The objective status of the external world (Megele, 2015) of particular relevance to CAMH practice is age, impacting on understandings of childhood, adolescence and mental health. The importance of listening to children has been clearly articulated in child protection contexts, with calls for child-centred approaches reflecting the value placed on children’s rights more widely. In adult mental health, an individual’s sense of personal agency is increasingly being recognized

as important for understanding mental distress and recovering from it (Tew, 2011). The rationale for involving children and young people in CAMH, then, is not only obvious, but further supported by evidence demonstrating that engagement facilitates therapeutic outcomes (Kim, Munson, & McKay, 2012) and mitigates against high drop-out rates (Oruche, Downs, Holloway, Draucker, & Aalsma, 2014). In practice however, young people continue to report being treated 'like a child' (Harper et al., 2013), suggesting practitioner and organizational responses to the issues of age and child status warrant further attention.

Few children and young people self-refer into CAMHS, so the help-seeking process tends to be initiated by a concerned adult, with children and young people frequently occupying the pre-contemplation stage of change (Prochaska & DiClemente, 1983). Presenting problems are first seen and heard through an adult lens, with control over identification, diagnosis and treatment situated within parental and professional systems. Research exploring initial conversations (where people and problems begin to be understood through an assessment process) found that some clinicians failed to seek children's accounts of their presentation to CAMHS, and among those children who were asked, many answered with 'don't know', a position that was maintained if the practice of deferring to adults for an explanation continued (Stafford, Hutchby, Karim, & O'Reilly, 2016). It appears that the processes through which we begin to engage with children and young people about their mental health might exclude them. To challenge the half-membership status (Hutchby & O'Reilly, 2010) experienced by children and adolescents, practitioners must involve them as active participants.

Shared decision-making can be challenging due to considerations about developmental stage and mental capacity (Wolpert et al., 2017). However, since 'power issues are closely implicated in the onset of mental distress' (Tew, 2011, p. 47), practitioners must consider the lack of control children and young people hold over access to and involvement with services. It is important to understand the impact of this position of powerlessness, at a time when, developmentally, many young people are striving for autonomy and independence from parents and carers. This issue is particularly pertinent for children with experiences of abuse or neglect, where interpersonal experiences may have further undermined their sense of control (Wolpert et al., 2017). A psychosocial perspective encourages practitioners to consider critically potential sources of conflict operating between the child's internal world (where lack of control may contribute to psychological difficulty and distress) and the social world (where age and child status can inhibit access to and engagement with support). Social workers, familiar with the idea of 'working with' rather than 'doing to', are in a strong position to ensure that psychosocial assessment processes 'underpinned by partnership practice and service user involvement' (Walker, 2011, p. 40) are fully embedded into CAMH practice. Champions of social justice and anti-oppressive practice, social workers have a role to play in developing practices and services that respect children and young people's rights and wishes to be 'kept well informed, included in the decision-making processes and encouraged to participate during consultations' (Coyne et al., 2015, p. 566).

A key principle of psychosocial practice is to understand the person as well as the problem they are presenting, which fits with the recurring research theme that children and young people experiencing mental health difficulty want to be listened to and understood (Bone, O'Reilly, Karim, & Vostanis, 2015; Plaistow et al., 2014). Humanistic counselling and person-centred approaches (see Chapter 3) provide a starting point for helping practitioners achieve this aim and are a good fit for current agendas in rights-based and therapeutic practice outlined above. Humanistic theory sees the wholeness of individuals, recognizing people as 'experts by experience', believing in their personal agency and capacity to effect change or build more fulfilling lives for themselves.

Humanistic theory facilitates psychosocial practice by encouraging practitioners to demonstrate effective personal relationship skills using the core conditions of empathy, genuineness and unconditional positive regard to build an effective therapeutic alliance. The way the practitioner *is* with children and young people matters far more than what they *do*. Research into CAMH services found that children and young people want practitioners to be approachable, friendly, warm and non-judgemental (Coyne et al., 2015). The knowledge, values and skills that social workers bring mean they are well placed to communicate effectively with children and young people experiencing mental distress and to model a Rogerian person centred/child-centred approach within their teams. It is through a supportive, warm and trusting relationship that the inner psychological experience of the child or young person can be explored and understood.

A range of interventions based on humanistic theory such as non-directive art and play therapy and school counselling are widely used in practice. Often delivered in mainstream settings and experienced as less stigmatizing, there are many benefits to such approaches. However, their effectiveness in CAMH is under-researched, possibly escaping rigorous evaluation because they are delivered in non-clinical populations. Alternatively, since humanistic approaches encapsulate a 'way of being' (Rogers, 1995), as opposed to techniques of doing, it is possible that they fail to be fully recognized within interventions literature and research.

Psychodynamic theories and therapies also aim to understand the person and share with humanistic approaches the position of being widely used in practice but under-researched and under-represented in CAMH literature. Methodological limitations such as including a mixture of conditions in empirical studies and a potential sleeper effect (McLaughlin, Holliday, Clarke, & Ilie, 2013) have been identified as particular challenges. At the heart of the original psychosocial model is a commitment to recognizing the inner psychological experience of the individual. Ideas such as transference, whereby intense emotions stemming from an earlier relationship are projected onto the practitioner by the client, and countertransference, a redirection of the practitioner's feelings toward the client, remain important for understanding relationships and can help young people process difficult experiences and make sense of the past.

A focus on defence mechanisms and relationship dynamics indicates the depth at which psychodynamic therapies operate, helping to explain why they are often used when other therapies have not worked or in highly complex situations: for example, where maltreatment or family trauma has occurred (Ghosh Ippen, Harris, Van Horn, & Lieberman, 2011). Psychodynamic practice encapsulates another important psychosocial tenet – to actively make use of the service user's relationship with the social worker. Some young people have not experienced a positive relationship with an adult, so the importance of offering a safe and containing relationship in which distress and difficulties can be explored should not be underestimated. Understanding attachment theory and the need to provide a secure base may be crucial to demonstrate that a different relationship template is possible. Relationships, the centrality of which is discussed by Winter (Chapter 12), form an essential component of contemporary psychosocial practice. Through containment, the capacities for reflexivity and mentalization can be developed, which arguably foster resilience.

Cognitive behavioural therapy (see Chapter 16) is often the treatment of choice for anxiety and depressive disorders in CAMH. Some CBT techniques have proved consistently effective for helping children and young people: graded exposure, for example, helps children and young people overcome fears, phobias and obsessive-compulsive behaviours, whilst modelling is helpful in anger management. Through enabling children and young people to make sense of the problems they experience within their current environments and challenge unhelpful thoughts and beliefs, CBT supports the psychosocial perspective of recognizing the inner psychological experience of the individual and the external social world, which may be in conflict. CBT

teaches children and young people specific techniques to modify thoughts, feelings and behaviours, potentially enabling them to help themselves in future. Research suggests young people value interventions that foster self-reliance (Plastow et al., 2014), so CBT might be particularly appealing for adolescents, especially computerized programmes. A range of CBT programmes has been developed for different age groups, and the specific disorders and conditions it aims to treat continues to grow – trauma-focused CBT is a recent addition.

Mindfulness (see Chapter 22) with children and young people is currently being researched, both as a stand-alone intervention and as a component of CBT. Group-based mindfulness programmes appear popular, their use in schools expanding. Amidst concerns about the sense of self developing in young people in Western countries, whereby identities are increasingly being shaped by consumerism, competition and social media, mindfulness has real potential. By encouraging a focus on being present in the here and now, mindfulness can intervene at the site of conflict between the inner psychological experience of the individual and their external social world. Promoting acceptance, effective response to stress, improved emotional regulation and sense of well-being, mindfulness offers a promising way forward in CAMH practice.

Psychosocial practice also fosters approaches that account for people's strengths and interests. A strengths perspective (see Chapter 18) applied to CAMH assumes that all children and young people (including those with severe emotional and behavioural difficulties) and their families have within them strengths, interests, abilities and characteristics that can be identified, encouraged and utilized to effect change, foster improvement, achieve goals and promote well-being. By shifting the focus of attention away from deficits and pathology, a strengths perspective can help overcome the stigma associated with traditional approaches and is therefore in keeping with the social work value base.

Some of the concepts associated with a strengths perspective are clearly evident in practice. Assessments routinely ask about goals and strengths, although this is usually an aside and does not mean strengths work has been fully embedded in practice. Originally developed for child protection work, *Signs of Safety* (Turnell & Edwards, 1999), which explicitly incorporates a strengths-based approach, has been used in CAMH to support, protect and safeguard young people who self-harm or engage in other high-risk behaviours. Strengths-based programmes are increasingly found within schools and community environments, suggesting that better use is being made of children and young people's external resources. Of the specific strengths-based programmes that have been implemented, rigorous evaluation using experimentally controlled outcomes studies are largely absent, and the programme content is not always made clear (Brownlee et al., 2013).

However, the influence of a strengths perspective is perhaps more evident as a component within other therapies, with a long tradition in family therapy and family-based approaches, for example. Solution-focused brief therapy (see Chapter 19), whereby goals for preferred futures are identified and strategies to achieve them are considered, also builds on strengths and resources. This intervention is gaining support from CAMH practitioners, perhaps because specific techniques such as scaling and the miracle question can be learnt, alongside a growing recognition that young people welcome positive practitioners, and because self-selected goals and solutions foster culturally sensitive and anti-oppressive practice. The evidence base for solution-focused therapy in CAMH is developing: tentative support now exists for children and young people experiencing internalizing and externalizing behavioural difficulties (Bond, Woods, Humphrey, Symes, & Green, 2013). Although the full-scale adoption of a strengths perspective has not yet materialized, it has an important role to play in the future of psychosocial CAMH practice.

Narrative therapies allow problems to be externalized, separating them from the child or young person. Counteracting the individualizing pathologizing processes discussed above,

narrative approaches adopt key psychosocial principles and allow for more constructive helping processes to be developed, often using creative and playful approaches. Again, narrative approaches are hard to locate in the research literature but used frequently in CAMH practice.

Child and adolescent mental health and mental health difficulty develop within a complex web of family and environmental systems (see Chapter 15); hence, adopting a holistic perspective and working in partnership with families is fundamental to a psychosocial approach to CAMH practice. The meaning attached to children's emotions and behaviours must be understood within their relationships and environments, an issue addressed within family therapy. Sometimes parents themselves are the focus of the intervention. For example, parent training, including non-violence resistance (NVR) training, is used to manage a range of emotional and behavioural difficulties. Modifying parental responses or patterns of interaction and making adaptations to a child or young person's home environment can be key to effecting change. At other times, parents and carers are the child's closest allies, enlisted as co-therapists, and playing a major role in spotting their child's negative thoughts, reinforcing positive or desired behaviours or noticing strengths and exception times.

Exploring family dynamics and people's positions and roles within a family is an important part of CAMH family work and can be helpful to support families to manage conditions such as anorexia and bulimia or where children have experienced trauma, neglect or abuse. The role of relationships is increasingly being recognized; hence, some of the newer attachment-focused interventions (see Chapter 13) such as Theraplay and dyadic developmental psychotherapy comprise sessions with children or young people and their parents. The use of family-based approaches such as multi-systemic therapy has risen in recent years, seeking to effect change in the contexts within which children and young people operate. Evaluation of these interventions is in its infancy and has produced mixed results. Benefits of family and systematic approaches include allowing multiple perspectives and hypotheses to be considered, bridging social care and mental health provisions, allowing strengths and resources to be activated and helping change family discourses and narratives.

Caregiver involvement is thought to improve mental health outcomes for children and young people and has been identified as improving adolescents' treatment experience (Oruche et al., 2014). However, there is a balance to be struck because parental attendance may also inhibit disclosure (Day, Carey, & Surgenor, 2006). A flexible appointment structure combining separate and joint appointments has been suggested by young people and their parents as a means of facilitating honest conversations that promote understanding in CAMH (Coyne et al., 2015). The age of the child, family dynamics, nature and causes of the presenting problem and selected intervention and support strategies may affect the level of participation required by caregivers, but sensitive and careful negotiation on a case-by-case basis and subject to ongoing review is also important.

Some parents or carers are in fact the perpetrators or facilitators of abuse, neglect or trauma. Close liaison with safeguarding and child protection staff and multidisciplinary input is required to ensure that children and young people's needs are met and that safety and well-being are prioritized. Engaging with other professionals is another key principle of contemporary psychosocial practice. Social workers have a thorough knowledge of child development, a good understanding of how parental factors and behaviours affect child development and well-being and a sound understanding of child protection and safeguarding procedures. This puts them in a key position to intervene directly and offer support or consultation to other professionals.

Social disadvantage such as poor education and poverty is linked to the development and maintenance of mental health problems. Unfortunately, the impact of the external social world on children and young people's mental health is often ignored or side-lined in practice. Walker



(2011) urges us to bear in mind our own prejudices and assumptions, examining how common stereotypes – for example, the view that young black males are aggressive – might surreptitiously be influencing our own practice. He reminds practitioners to work in partnership with the child or young person and their family to understand their perspectives and belief systems in a bid to develop practice that is culturally competent.

The wider contexts in which children and young people operate are beginning to receive greater attention, giving rise to more community-orientated practice. A variety of social interventions exist, and whilst experimental research for these lags well behind psychological and pharmacological interventions, the value of prevention, early intervention and fostering resiliency is clear. The evidence for school-based interventions, which are socially inclusive and non-stigmatizing, has grown rapidly in recent years. Successful interventions focus on positive mental health, deliver a mix of universal and targeted approaches, start early with younger children and include parents and community involvement, as well as co-ordinating work with outside agencies (Weare & Nind, 2011).

## Conclusion

A contemporary psychosocial model of social work for CAMH practice ‘offers the optimum framework to take account of all the individual, child, family and environmental variables interacting to produce the identified difficulties’ (Walker, 2011, p. 18). Presently, the social aspect of the psychosocial approach is under-utilized. Embedding a psychosocial perspective more fully into CAMH practice provides a promising way forward to engage in culturally and socially inclusive practice to promote and support the mental health of children and young people.

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