UNIVERSITY OF BIRMINGHAM

INTRODUCTION

In this assignment I intend to examine issues surrounding the mental health of young people with profound and multiple learning difficulties and to answer the question: *what do teachers need to know about the mental health needs of their pupils with PMLD and why?* In doing so, I will address the following issues with relation to the target group:

- The incidence of mental illness compared to the general population
- Vulnerability to mental illness.
- Issues with the diagnosis of mental illness.
- Issues with treatment of mental illness.
- The impact of mental illness on families and carers.
- Ways of promoting mental well-being within special schools.

I will address these issues with a combination of quantitative and qualitative data obtained through a review of relevant literature, practical research within my own school, and an illustrative case study.

By 'young people' I usually refer to people aged 14 – 19 years, although as will be seen, a relative lack of sources about the mental health of young people with learning difficulties compared to adults means that at times it will be necessary to extrapolate from literature about adults.

The terms 'profound and multiple learning difficulties' (PMLD) and 'complex needs' are interchangeable in this assignment although this is not always accepted practice. They refer to young people who have been assessed at functioning between approximately levels P1 and P4 of the UK National Curriculum P-Levels, or can be placed at between approximately the levels of 'encounter' and 'exploration' on the OCR Entry Level Achievement Continuum.

For the purposes of this study, the term 'mental illness' refers to levels of emotional, psychological or psychiatric distress that present significant challenges for young people, their families and those who support them. Types of disorders fall broadly within the categories defined in DSM-V, the standard manual of psychiatric disorders:

- Non-affective disorders (i.e. not effected by emotions and moods) such as schizophrenia

- Affective disorders (i.e. disorders linked to mood or emotion) such as depression and anxiety.
- Neurotic and stress-related disorders and phobias such as OCD and agoraphobia
- Eating disorders such as anorexia nervosa
- Hyperkinetic disorders such as ADHD
- Conduct Disorders such as self-injurious behaviour (SIB)

It is also important for the purposes of this study not to assume that the term 'mental health' only refers to mental illness. As Pilgrim (2010) reminds us, the term 'mental health' can be used positively to indicate a state of psychological well-being, and negatively to indicate its opposite. Good mental health will also be part of this study and is enshrined in the UN Convention of the rights of the child (1989) as follows: *Health is the basis for a good quality of life and mental health is of overriding importance in this.*

We will be using the definition of 'mental health' as set out by the World Health Organisation (2010) as '*a state of mind in which an individual is able to realise his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community*'

The relationship between mental health and learning difficulty is widely acknowledged as being complex and misunderstood (Rose, Hawley and Fergusson, 2009) and this relationship is further complicated when a young person has complex needs or struggles to communicate in a conventional way.

From a historical perspective, this relationship has always been subject to changing customs and influences (Pilgrim, 2010) and it is useful briefly to look at the historical patterns of convergence and divergence.

At around the start of 19th century there was a mass segregation of a range of 'deviant' populations into hospitals, asylums, workhouses etc. (Digby and Wright 2002). This meant that those with what we might now refer to as 'learning difficulties' and those with what appeared to be mental illnesses were commonly placed together within the same institution. This convergence of mental illness with learning difficulty was enshrined in The Lunacy Act of 1845 whereby 'idiots, lunatics, or persons of unsound mind' were to be detained in asylums.

However, towards the end of the 19th century there was a gradual legislative division between 'idiocy' and 'lunacy' (the Idiots Act, 1886; the Lunacy Act, 1890) and there was further legislative separation of learning difficulty from mental illness in the Mental Deficiency Act of 1913 and the Mental Treatment Act of 1930.

The maintenance of this conceptual distance may however have had the effect of implying that people with learning difficulties are somehow immune from mental health issues or that

the mental health needs of those with learning difficulties may have been neglected. This is an important area of this study as it relates to young people with complex needs.

The issue of clarity persists today in Government policy. Despite the intentions of the current government to ensure that mental health is on an equal footing with physical health, the foreword to *No Health without Mental Health* (2011) only describes the government's intention to expand *provision for children and young people, older people, people with long-term physical health problems and those with severe mental illness.* The mental health needs of people with learning disabilities, let alone those with the most complex needs, are not mentioned until page 60 of the 105 page document where it states: *The special educational needs and disability Green Paper will consider, among other things, how to make sure that there is better early intervention to prevent later problems for children with special educational needs and disabilities, including those who have underlying or associated mental health problems.* Issues with diagnosis and treatment posed by a lack of communications skills are only mentioned in the context of deaf people.

The more recent paper 'Closing the Gap (2014)' as well as the 2010 document 'Valuing People Now' make no specific reference to the mental health needs of people with learning difficulties and only mention mental health as one of a list of issues to be addressed which includes learning difficulties, implying that the two issues may be separate. 'Valuing People Now' (2010) only mentions one region of the country where any progress has been made in supporting the mental health needs of people with learning difficulties.

In the new Special Educational Needs and Disability Code of Practice (January 2015), although the phrase 'mental health' appears 34 times, none of these instances are in the context of young people with complex needs and in fact there is an underlying implication in the document that the conceptual distance mentioned above persists, with the phrase '*learning difficulties or mental health issues'* (my italics and underscore) occurring twice in separate sections (6.21 and 6.22)

In seeking to to clarify the relationship between complex needs and mental health, Rose, Howley and Fergusson (2009) have identified two areas of concern for many professionals working in this field: the difficulty of identifying mental health difficulties in young people with complex needs, and the challenges of distinguishing between features of a named learning difficulty and possible indicators of mental health problems. In other words, to what extent we are able to identify a mental health condition which is 'co-occurring' but not necessarily a direct consequence of the primary diagnosis?

According to Bond (2013) school is one of the key environments in which mental health problems can be identified and support provided. Because of this, I will be using the findings of the literature review and practical research at my own school to create a short guide to the mental health of young people with learning difficulties (Appendix 3) for limited distribution to teachers in my school.

LITERATURE REVIEW

In conducting a review of recent literature, I want to explore the key issues I raise in my introduction:

- The incidence of mental illness compared to the general population
- Vulnerability to mental illness.
- Issues with diagnosis.
- Issues with treatment.
- The impact of mental illness on families and carers.
- Ways of promoting mental well-being within special schools.

In reviewing recent literature however, it became clear that much of the literature concerns young people with mild to moderate learning difficulties. The mental health needs of young people with complex needs can be said to be a neglected area, and I have at times had to refer to older sources (pre 2005) in order to make a specific point where there has been no research since or where I have found it useful to draw comparisons.

1) Incidence

This section is concerned with the statistical evidence of mental health issues in the target group, and its relationship to the population as whole.

Mental illness is a significant issue in the general population of the UK. In a recent article in The Guardian newspaper (December 2014), Professor Ari Darzi, raising concerns about the dramatic rise of 10 to 14 year olds admitted to Accident and Emergency wards with self-inflicted injuries, reminds us that one in ten children under the age of 18 in the UK – or 1.3 million young people - has a diagnosable mental illness, mainly anxiety, depression or conduct disorder. These statistics are equivalent to those established by the Department of Education in its report *Mental Health and Behaviour in Schools* (2014) which states that one in ten children and young people aged 5 to 16 have a clinically diagnosed mental health disorder and around one in seven has less severe problems. Within the general population, 5.8% have a conduct disorder, 3.7% have emotional disorders, and 1.5% hyperkinetic disorders. 1.9% of all children are diagnosed with more than one of the main categories of mental disorder. These statistics are also reflected by Bond (2013) in the Young Minds report *Children and Young People with learning disabilities – understanding their mental health,* which states that at any given time about 17% of all children aged 6 – 16 will be experiencing anxiety or depression and between 1% and 2% will experience a more serious problem such as bipolar disorder or psychosis.

In comparing these statistics with those for young people with learning difficulties, there is agreement (Holt and Hardy 2005, Bond 2013, Dept. of Health 2011) that rates are higher for those with learning difficulties. Statistically however, figures can vary. Without particular reference to age, Holt and Hardy (2005) give a prevalence of mental illness for all people

with learning difficulties as between 10% and 50%, while Goward et al (2005) put the range at between 10% and 80%. With respect to young people, the Foundation for People with Learning Disabilities in its *Count us In* report of 2002 gives a figure of 40% with an additional mental health issue, equating to approximately 40000 young people at any one time. This figure of 40% has been confirmed more recently by Bond (2013) and The Department for Health (2011) and is comparable to statistics from some other countries with Australia at 40% and South Africa at 31%: (www.complexneeds.org.uk)

Most statistical studies draw their conclusions from a range of levels of learning difficulties and in some cases include those with specific learning difficulties such as dyslexia. It is difficult to isolate statistics for young people with complex needs. However, Moss et al (2000) found that there was a strong correlation between challenging behaviour as an indicator of mental illness and level of learning difficulty, and Tsiouris (2001) used DSM IV criteria to diagnose depression in people with profound learning difficulties and found behaviours 'equivalent of depression' were more prominent in subjects with PMLD compared to those with mild to moderate learning difficulties. Bradley et al (2004) found a significant increase in symptoms of mental illness using the DASH II criteria (Diagnostic Assessment for the Severely Handicapped) in young people with autism and severe intellectual disability compared to those with autism alone.

People with learning difficulties suffer from the same types of psychiatric disorders as people of 'average intellect' (Holt and Hardy, 2005), though not necessarily in the same proportions. The *Count Us In* report (2002), for example, found that young people with learning difficulties are more inclined to develop emotional difficulties such as depression and anxiety, and Emerson and Hatton (2007) and Ghazziuddin (2005) found that children with learning difficulties are 8 times more likely to have ADHD than those without learning difficulties, 6 times more likely to have a conduct disorder, 4 times more likely to have an emotional disorder, 3 times more likely to experience schizophrenia, and 1.17 times more likely to have a depressive disorder. Cooper et al (2007) find that of the approximately 40% of people with learning difficulties who have a mental illness, 22.5% have problem behaviours, 6.6% have depressive disorders, 4.4% psychotic disorders, and 3.8% anxiety disorder, whilst the Royal College of Psychiatrists (2001) found that up to 35% of adults with a learning difficulty are obese, which may be an indicator of an eating disorder. These statistics reflect early findings of Volkmar and Cohen (1991) who studied 163 patients with autism and found 41 in whom there were symptoms suggestive of schizophrenia.

Ghazziuddin (2005) reminds us that people with some types of learning difficulty are more prone to certain forms of mental illness, with depression common in people with Down syndrome, and anxiety as well as distinctive patterns of abnormal eating often present in people with autism. Mania can also be present in adolescence in those with autism. The *Count Us In* report (2002) points out that people with Williams Syndrome and Fragile X can show a high incidence of a range of mental health issues. Ghazziuddin (2005) is also one of the few sources who is able to draw specific conclusions about our target group of young

people with complex needs showing that Self Injurious Behaviour is higher in those who have 'severe mental retardation and multiple pathologies'.

2) Vulnerability

In the general population, mental illness is usually caused by a combination of biological, genetic and environmental factors. The causes and effects of changes in the emotional and mental well-being of people with profound and multiple learning disabilities are similar to those in the general population (*Making Us Count, 2005*). We also have to take into account however a very complex interaction of often multiple biological, psychological, social and family factors (Holt and Hardy, 2005). The Royal College of Psychiatrists (2001) describes various methods of studying the aetiology of mental illnesses in the target group including biological and physical factors, social factors and factors related to developmental level.

For the purposes of this study then we will look briefly at vulnerability with relation to biological, psychological and social factors, while accepting that there is significant overlap between them.

In child psychiatry (Ghazziuddin, 2005), the association of a disorder with other conditions is often the rule not the exception so that medical and psychiatric conditions often occur together, with internal triggers such as pain, physical illness and puberty often leading to psychiatric distress especially where the patient struggles to describe that pain. Perry et al (2011) note that underlying brain damage, genetic factors and sensory impairment can lead to an up to fourfold increase in vulnerability to mental illness in people with learning difficulties, and also point out that between 40% and 60% of people with complex needs have some form of epilepsy against 1% of the general population. People who have epilepsy in all groups have a high rate of psychiatric disorders.

Psychological stress can arise because of the inability of people with complex needs to control their environment or to prevent or adjust to threatening situations (*Making us Count, 2005),* and Solomon (2011) notes that some of the biggest stressors for people with disabilities of all kinds are often humiliation and a sense of being trapped. Reactive depression (Holt and Hardy, 2005) commonly follows life events such as the loss of a significant carer, friend or pet, or placement changes, but may not be recognised as they may be seen as less significant for someone with complex needs. People interviewed for the *Making us Count* report (2005) indicated that bereavement and parental separation were causes of major changes in the emotional and mental well-being of people with profound and multiple learning disabilities. Adjustment disorders (Perry et al, 2011) are also common, and Turk and Brown (1993) noted that stress in the carer population can exacerbate stress in the cared-for.

Rose, Howley, Fergusson, and Jament, (2009) note that factors such as poverty and isolation also impact on mental health and are frequent in families of people with complex needs. People with learning difficulties are more likely to experience living circumstances and life

events associated with an increased risk of mental health problems (Goward, et al. 2005) with precipitating factors including poor social support, a lack of intimacy and social integration, social isolation and exclusion (Holt and Hardy, 2005). According to *Count Us In* (2002), 57% of young people with learning difficulties and mental health issues live below the poverty line, 30% live in the top 20% of Britain's most deprived areas, and 40% are being brought up by a lone parent. In addition (Bond, 2013*),* they are likely to have fewer friends and are less likely to be able to find adaptive solutions to life's challenges. Maintaining factors are also likely to include low levels of activity which are associated with depression (*Making us Count, 2005*). Turk and Brown (1993) also report that people with learning difficulties are vulnerable to sexual abuse, with challenging behaviour a frequent response to trauma of this type.

3) **Issues with diagnosis**

There are considerable difficulties in diagnosing psychiatric or psychological problems in young people with learning difficulties and in particular in those with complex needs, (*Count us In*, 2002) and as a result these types of problems often go unrecognised. At the extreme end of misdiagnosis, we are reminded (Ghazziuddin, 2005) that some people believe that people with autism cannot develop psychiatric disorders because autistic people lack the cognitive and emotional maturity to experience such states. As we have seen however, developmental disorders are distinct from psychiatric illness, and people with the first are highly likely to develop the second (Royal College of Psychiatrists, 2001).

Half of all people with learning disabilities do not get an annual health check (*Valuing people now*, 2010) and although GP's tend to be the first port of call (*Count Us In*, 2002) they are often ill equipped to deal with mental health problems in the target group. In the UK, medical schools devote only a few days in a five year course to training students about the specific health care needs of people with disabilities (complexneeds.org.uk), and there can be a lack of knowledge and training in the field of learning difficulty and mental health by carers, families, teachers and other professionals (*Making Us Count*, 2005).

The classification of learning difficulties can also impact on accurate diagnosis. For example, autism is usually seen as a pervasive development disorder, while autistic spectrum disorders can be placed under a heading of mental health (Rose, Hawley, Fergusson and Jament, 2009).

Goward et al (2005) point out that the most widely used manuals for the classification of mental illness – the Diagnostic and Statistical Manuals (DSM) and the International Classification of Diseases (ICD) may not be applicable to the experiences of people with severe and complex needs as they tend to classify mental health problems as changes from normal, whereas symptoms in people with complex needs may not have changed for years. Labelling someone as being either mentally ill or learning disabled, or both, (Holt and Hardy, 2005) is also culture-bound to a certain extent, with symptoms and behaviours interpreted by

professionals and compared against a cultural norm, where that cultural norm might not be shared by the person being diagnosed.

Rose, Hawley, Fergusson and Jament (2009) describe the complexity of the relationship between individual needs, specific disorders, general health and mental health problems, and show that the boundaries between the characteristics of diagnosed conditions and possible mental health issues are often unclear. Reiss (1993) first coined the term 'Diagnostic overshadowing' to describe a process whereby clear signs of a psychiatric disorder are inappropriately attributed to a person's learning difficulty and are not seen as resulting from mental health needs. For instance (Royal College of Psychiatrists, 2001), just because Down's syndrome can be associated with dementia, does not mean that we have to assume they are aetiologically linked in every case. Similarly, eating disorders can be a required clinical feature of Prader Willi syndrome, but an additional condition in other pervasive developmental disorders.

A key issue in the diagnosis of mental health conditions in the target group (Holt and Hardy, 2005) is the fact that these young people are rarely able to communicate verbally. Most people with complex needs lack the communication skills to say they are feeling anxious or unhappy, and psychoses or conditions such as schizophrenia are particularly difficult to diagnose when individuals are unable to verbalise experiences such as hearing voices. Social functioning as a key factor in the diagnosis of mental illness is also difficult to assess. Diagnostic criteria, according to The Royal College of Psychiatrist (2001) are predicated on their use by the general population and weighted towards verbal items.

Young people with complex needs may also present with unusual or infrequent symptoms (Bond, 2013, Holt and Hardy, 2005). Diagnosing OCD, for example, in young people with an autistic spectrum disorder is particularly challenging (Reaven and Hepburn, 2003; Volkmar and Cohen 1991) because of the difficulty teasing apart the stereotyped behaviours common in autism from the presence of obsessions and compulsions.

Crucially, psychiatric disorders (Perry D et al, 2011; Turk and Brown, 1993) such as depression can present atypically as behavioural problems including aggression or self-injurious behaviour. The fact that for many people with complex needs changes in behaviour may be an indicator of an underlying mental health conditions (Bond, 2013) means that accurate diagnosis depends on being able to identify which behaviours may be a direct consequence of the learning difficulty and which are not. Bond (2013) reminds us that a change to an established behaviour may be a better indicator than a long established behavioural phenotype, although Perry (2011) is careful to point out that this is not a completely reliable diagnostic tool as it is not uncommon for people with learning difficulties to have had a psychiatric condition for longer before diagnosis than in the general population. The nosology of problem behaviours is complex (Royal College of Psychiatrists 2001). Even once a change in behaviour has been noted (Coughlan, 2010) there is often a tendency to try to explain 'unusual' or 'bizarre' behaviour, purely from a behavioural perspective or framework and to describe these behaviours as being attention-seeking or 'deliberate'.

Carpenter, Coughlan and Fotheringham, (2001) stress the need to challenge these assumptions, and examine whether there may be an underlying mental health component, and Meins (1995) coined the term 'behavioural depressive equivalent' to describe atypical symptoms and suggested they be included in the diagnostic manuals.

Accurate and timely diagnosis then depends on maintaining a high level of suspicion (Royal College of Psychiatrists, 2001), and maintaining good communication and close liaison between family, carers and members of the multi-disciplinary team. Interviews with family and carers (Making Us Count, 2005) can be as good as first-hand information, and the *Making Us Count* report (2005) highlights research from a team at the University of Dundee which showed that changes in the emotional and mental well-being of young people measured by standard diagnostic instruments were consistent with the specific signs reported by family carers. Warning signs (Perry et al, 2011) can include loss of enjoyment in activities; fear and agitation out in the community; loss of established skills; increase or decrease in vocalisation; appearing to listen to or watch something which is not obvious to others; onset of self-injurious behaviour , aggression, and changes in sleep pattern.

4) **Issues with treatment**

Mental health care for people with learning difficulties remains a relatively new concept and services are still in their infancy (Ghazziuddin 2005). There is a high prevalence of mental health issues in the target group, but there is at the same time a low utilisation of mental health services.

Issues affecting diagnosis and treatment overlap significantly in the target group, particular with respect to communication and behaviour, though in addition Bender (1993), quoted by Goward et al (2005) coined the term 'therapeutic disdain' to describe the relative lack of interest shown by professionals in the psychiatric problems of people with learning difficulties.

The *Making us Count'* report (2005) showed that those requiring help often encountered difficulties in getting appropriate services, and pathways to referral for help and support were vague. There were often long time delays to access assessment and treatment and young people were shunted between mainstream and specialist services, despite the fact that the report *Mental Health and Behaviour in Schools* (2014) recommends that where severe problems occur schools should expect the child to get support from medical professionals working in specialist Child and Adolescent Mental Health Services (CAMHS), voluntary organisations and local GPs. .However (*Making us Count,* 2005*)*, frontline staff often lack vital knowledge in coping with the effects of changes in the emotional or mental well-being of young people with complex needs.

Mental health issues in people with learning difficulties can and should be treated, and although the core features of the developmental disorder may not improve with treatment, symptoms of depression, anxiety and more severe problems can. The *Count Us In* report

(2002) reminds us that there are three main strands to the treatment of mental illness in the general population: biological, psychological and psychosocial / environmental, but only the first and third may be appropriate to people with severe or complex learning difficulties. The second of the three strands of treatment, often referred to as 'talking therapies', is often of little use with people with complex needs and communication difficulties because for treatments of this kind to be successful (Holt and Hardy, 2005) people need to be able to make sense of causal relationships such as the consequences of an event, and to understand the degree to which their lives are being restricted by their condition.

According to Perry (2011) biological interventions in the form of psychotropic medications are prescribed to over 30% of people with learning difficulties. There can be an over-reliance on medication (*Count us In,* 2002*)* and a lack of knowledge about appropriate dosage or possible side effects for someone with learning difficulties, particular when taken at the same time as other essential medication.

The issue of prescription of drugs raises the question of mental capacity and consent in people with complex needs. Annexe I of the Mental Capacity Act (2005) is clear on this: where someone lacks the mental capacity to make a clear decision (to take prescribed medication), that decision will be taken by a representative on their behalf (Nettleton and Friel, 2015).

Psychosocial and environmental treatment can be more useful (Perry et al, 2011), and include modifications to living environments or other circumstances which impact on the young person. Carpenter et al (2011) cite Abbey Hill School for children with complex needs, many of whom have mental health issues. Small nurture groups with high staff/student ratios build trust and a sense of emotional security and are one of a range of interventions offered to children identified as vulnerable.

5) Impact on families

This is an area where there is a shortage of literature. Ghaziuddin (2005) recognises that the parents of children with autism as well as their siblings show an increase in anxiety and depression. Attachment disorders (*Count Us In,* 2002*)* are also common as parents struggle to come to terms with having a child with complex needs. The stress of caring can be an enormous burden (*Making Us Count,* 2005*),* and carers need assistance to find avenues of mutual support. Short term respite care and a range of other support can be vital for the families. Clearly then (Ghazziuddin, 2005) the identification and treatment of mental health problems in people with autism leads to an improvement in their quality of life and that of their families and carers.

6) Supporting mental Health

In my introduction, I stated that 'psychological well-being' (Davidson, 2008), is an important aspect of this study. Any child who is not in a state of mental well-being (Davidson. 2008) is at risk of poor mental health and young people with complex needs should expect the same standard of mental health care as the rest of the population (Holt and Hardy, 2005).

An important key to promoting children's mental health (*Mental Health and Behaviour in Schools, 2014)* is an understanding of the protective factors that enable children to be resilient when they encounter problems and challenges. The word 'resilience' describes the attributes of children who seem able to cope with difficulties, and although people with learning difficulties may have less of this resilience, it is possible (Rutter, 1985) to foster a sense of self- esteem and confidence and a repertoire of problem solving approaches. The Count *Us In* report (2002) recommends a person-centred approach, getting to know the young person and their environment, and ensuring that a regular and consistent staff team around the young person make him or her feel valued. Other actions to support emotional well-being (Rose, Howley, Fergusson, and Jament, 2009) must address familial and environmental factors that may have a negative impact.

Darzi (2014) shows that schools occupy a key role in protecting the mental health of children, and the *Mental Health and Behaviour in Schools* report (2014) recommends working with parents and carers as well as with the pupils themselves, professional development for staff, clear systems of identification and intervention and fostering a 'sense of connectedness' through belonging to the school community.

DATA COLLECTION

I now intend to test the findings from my review of recent literature with practical research at my own school, which is an all-age special school in the UK with 120 pupils who display a range of learning difficulties from mild to severe and complex.

I will present quantitative data from teachers at the school of the incidence and diagnosis of mental illness in the target group, and compare the actual and suspected rates of mental illness in the school with national statistics. I will then present some qualitative information about the impact on families and about approaches to maintaining mental wellbeing.

My method for collecting data at the school was to devise and distribute a questionnaire (Appendix 1) to the 21 teaching staff.

The first issue I had to address was one of confidentially. I wanted to try and make sure that it was not possible to link any of the completed questionnaires with any particular class, teacher or individual pupil. I added the following paragraph to the introductory remarks on the questionnaire:

This is a confidential questionnaire, so please do <u>not</u> add your name, the names of any of your pupils or the name of your class. All questionnaires will be shredded as soon as I have analysed the data.

I emphasised that the purpose of the questionnaire was not to identify mental health problems in pupils. I stressed that the first 4 questions were statistical and the last 2 questions called for a brief reflection on the impact on families and on supporting mental well-being.

A further issue was that although the school does have 2 classes which specifically receive young people with profound and multiple learning difficulties, issues of confidentiality meant that I would not be able to target the questionnaire at these groups, but would have to devise ways of trying to identify incidence of mental illness in the target group without identifying individuals.

Of the 21 questionnaires distributed, I received 9 completed replies, or 43%. This was a low response rate, in part explained by the fact some teachers share classes and others are not class teachers but have cross school subject responsibilities. This does not mean that responses from those teachers would replicate responses from class teachers, because only one of the questions (Question 3) called for firm knowledge of diagnosis based on student records.

I will now address each question, examine the responses, and compare and contrast those responses against the findings of the Literature Review.

- **Question 1: How many pupils are there in your class?**

The smallest class sizes were 5 (2 classes) and the largest 11 (1 class). There were 3 classes with 7 pupils, 1 with 8, and 2 with 10. The average class size was 7.8 pupils per class. Responses covered 70 pupils in total, or 58% of the total cohort of the school – a significantly higher proportion than the number of questionnaires received.

- **Question 2: Of these, how many do you think are classified as having mild, moderate, severe, and profound and multiple learning difficulties?**

The aim of this question was to try to isolate statistically pupils with profound and multiple learning difficulties.

The classes with the highest statistical number of pupils with profound and multiple learning difficulties were a class of 5, where 5 (100%) were listed as having PMLD, and a class of 7, where 5 (71%) were listed as having PMLD. Of the 70 pupils covered by the questionnaires, 14 (20%) were described as having PMLD. This was equivalent to the total number of pupils in the school who are classified according to school records as having PMLD.

- **Question 3: Of the total number of pupils in your class (Qu. 1), how many do you know have a diagnosed mental health condition, such as anxiety, depression, OCD, schizophrenia, ADHD, in addition to their primary diagnosis? Please then try to calculate that number according to classifications in Question 2.**

This is the only question which calls directly for statistical information based on student records. In theory, it would have been possible to use statistics for the whole school based on records kept centrally and the Head Teacher had offered to release some of these records to me. However, in view of the high rate of response to the questionnaires by teachers of pupils with PMLD (see above), and the difficulty of isolating specific information about mental health from longer confidential documents it was decided to use only the statistical information gathered in this question.

With respect to the total number of pupils referred to in the questionnaire (70), representing a range of learning difficulties, 5 (7%) were known to have a diagnosed mental health issue. This percentage is lower even than the general population of the UK, where recent studies (Darzai, 2014, and *Mental Health and Behaviour in Schools*, 2014) broadly agree that the incidence rate is around 10%. It is significantly lower than the rates of between 40% and 80% of the population of young people with all learning difficulties. Of the 14 pupils identified in Question 2 as having profound and multiple learning difficulties, only one (7%) was known to have a co-occurring mental health issue, which again contrasts with the data from the literature review where there is general agreement (Tsouris, 2001, Bradley et al,

2005) that incidences are higher in those with PMLD compared to all other learning difficulties.

- **Question 4: Of the total number of pupils in your class (Qu. 1), how many do you <u>suspect</u> have an undiagnosed mental health condition, such as anxiety, depression, OCD, schizophrenia, ADHD, in addition to their primary diagnosis? Please then try to calculate that number according to classifications in Question 2.**

The aim of this question was to try to shed light on issues of 'diagnostic overshadowing' and 'therapeutic disdain' described in the literature review.

With respect to the total number of pupils referred to in the questionnaire (70), a further 20 (28.5%) were suspected of having an undiagnosed mental health issue. When added to the results from Question 3 above, this gives a figure 25 (36%) of all pupils with a known or suspected mental health issue. This percentage now approaches the lowest estimated figure of 40% of the population of young people with all learning difficulties. Of the 14 pupils identified in Question 2 as having profound and multiple learning difficulties, a further 4 (29%) were suspected of having an undiagnosed mental health issue. When added to the results from Question 3 above, this gives a figure of 5 (36%) of PMLD pupils with a known or suspected mental health issue. This is the same percentage as for the pupils as a whole which again contrasts with the data from the literature review regarding the increased incidence of mental illness in the PMLD population nationally.

Discussions and Conclusions from quantitative data (Questions 1 – 4)

With respect to the means of gathering data, a questionnaire distributed to 21 teachers in one special school provides only a very small sample from which to draw conclusions. However, I had distributed questionnaires to other special schools in my region as part of the research into 2 of my last assignments, and despite the support in each case of a member of the senior leadership team in these schools and an assurance that the questionnaires would be followed up, none were returned. For this reason, and taking into account the potentially sensitive nature of the information I wanted to gather, I decided that I would focus my research only on my own school.

Nevertheless, it is possible to draw three significant conclusions from the data gathered.

The 7% incidence of a diagnosed co-occurring mental health condition across all 70 of the pupils sampled is lower even than the general population (10%) and as such shows that at least in the school surveyed some young people with learning difficulties may not be receiving an appropriate diagnosis of their mental health needs.

With respect to the target group, the fact that the statistical incidence figures (known and suspected) of 7% and 36% do not change for the PMLD group points to a very real issue with diagnosis in those with complex needs.

However, the sharp statistical rise from 7% to 36% when considering pupils who their teachers suspect have an undiagnosed mental health condition shows that the need for a 'high level of suspicion' (Royal College of Psychiatrists) is very real. The responses to questions 5 and 6 on the questionnaire, which I will now analyse, provide qualitative data to support the conclusion that the teaching staff are able to reflect in very positive ways on the mental health needs of their pupils.

- **Question 5: In very general terms, what do you think the impact of additional mental health problems has had on your pupils and their families and carers?**

With respect to the impact of co-occurring mental health issues on the pupils themselves, respondents consider that these represent a significant additional disability and may make it more difficult for pupils to access activities and the world around them as they may have done previously irrespective of the level or nature of their learning difficulty.

In particular, respondents reported a high incidence of selective mutism in their pupils which makes it difficult for them to express themselves and receive diagnosis or support, and others reported that behaviours linked to co-occurring OCD behaviours can make any changes to routine very difficult and in some cases lead to aggression which impacts on all pupils and staff.

The answers to the second part of this question were illuminating in particular because there was a paucity of research evidence from the literature review about the impact of mental illness on the families of people with learning difficulties, and a proposed questionnaire to families and carers (Appendix 2) was withdrawn.

There was a consensus of opinion amongst respondents that the impact of co-occurring mental illness on a the family of a child with learning difficulties is potentially very significant, with one respondent describing the impact as 'devastating' with parents' lives completely dominated by the child's anxieties and associated behaviours. Mental illness in the target group is reported as leading to a restricted social life for families, strained relationships between family members and financial difficulties where one or both parents are unable to work in order to support their child. This can be exacerbated where parents are unable to recognise or acknowledge a mental health issue in their child and therefore not get appropriate support. One respondent made the point that as a child with learning difficulties moves into secondary education, the onset of puberty can also bring with it further challenges for parents and carers

- **Question 6: In what ways do you think we as teachers can actively promote and maintain good mental health in our pupils?**

The most common response was that effective communication is one of the best ways of supporting good mental health in the pupils. This might involve providing a space for discussion, being a good listener, and finding ways for pupils to talk about their emotions. Enhancing 'emotional literacy' as more than one respondent put it. This includes having open communication and a good relationship with parents and carers, so that a 'baseline' is established and changes (in behaviour) noted and acted on in a timely way.

Several teachers focussed on the importance of providing an environment at school which helps reduce anxieties in the pupils and of providing activities where pupils are able to achieve and feel positive. Several mentioned the importance of being flexible in terms of group numbers and rooming whilst at the same time ensuring continuity of staff and a staff team that knows each pupil well enough to recognise small changes in behaviour which may be indicative of a mental health issue.

Staff training in how to recognise mental health conditions is also highlighted by several respondents, as is the importance of input from external organisation which can provide support and training.

Discussions and Conclusions from qualitative data (Questions 5 and 6)

It is clear from the responses that teachers in this school do maintain a 'high level of 'suspicion' (Royal College of Psychiatrists, 2001) and are aware of the impact of co-occurring mental illness on the pupils and their families. In line with the findings of the literature review, there is less specific awareness of the needs and vulnerability of pupils with PMLD with the emphasis on supportive practices which assume a level of communication not necessarily present in the target group. However, many respondents emphasised the importance of a person centred approach, getting to know each pupil, ensuring a stress free environment and consistency of staff, all of which are recommended in the *Count Us In* report (2002), as well as taking a multi-agency approach and working closely with families and carers as recommended in *Mental Health and Behaviour in School* (2014).

Of the six issues I chose to address in this study, it has not been feasible to compare findings from the literature review on vulnerability with data collected through practical research. To address this issue, I will now present a brief case study of one pupil in my own class.

CASE STUDY

I will now present an illustrative case study of a young person with complex needs who does not have an additional diagnosis of mental illness. I will examine his vulnerability to mental illness, and look at whether his behaviours may be symptomatic of a mental health issue.

This case study is not a diagnostic tool. It is about vulnerability with reference to the findings of the literature review and suspicion based on observed behaviours.

'D' is a 16 year old pupil at a special school. He has a diagnosis of autism. His verbal communication is limited to a few very quiet words and short phrases. He is classified by the authorities as having profound and multiple learning difficulties (PMLD) and is placed in a class with other pupils with PMLD. There is no indication in any of the formal documents held about him that he has any co-occurring mental health issues.

He has a diagnosis of gluten intolerance, and his GP has suggested that he follows a gluten and dairy-free diet because this may impact positively on his behaviour.

With respect to D's vulnerability to mental illness, I have used the Royal College of Psychiatrists' (2001) suggested biological, psychological and social factors as set out in the literature review above.

Ghazziuddin (2005) suggested that internal triggers such as pain, physical illness and puberty often leading to psychiatric distress especially where the patient struggles to express or describe that pain. In D's case his gluten intolerance can lead to stomach pains and flatulence. He is also a boy who has been going through puberty, has grown a great deal in the past year, and is very thin. However, his diet has been restricted and he is frequently denied access to the food shared by his peers especially at times of celebrations such as birthdays etc.

In line with Solomon (2011) who suggests one of the biggest psychological stressors for people with disabilities of all kinds is a sense of being trapped, D's behaviour deteriorates at school when he is enclosed in noisy environments or in classrooms and is unable to access the playground or quiet areas. His participation in community trips is restricted when in school because of fears over his behaviour. His behaviour has however been shown to be appropriate when out in the community with his mother at weekends and in the holidays

Solomon also notes that stress in the carer population can exacerbate stress in the cared-for. D's parents have struggled with him in the past and experience high levels of stress. His siblings – who have been treated for depression – are kept apart from D in the home environment

Socially (Goward, et al. 2005) D has limited support in the family, and a lack of intimacy with his father in particular. D can be said to be isolated (Holt and Hardy, 2005) and although

he does spend time with a boy of a similar age who also has severe autism, this represents his only social contact outside his immediate family, the school and support agencies. He does not access respite care and the family have not taken him on holiday for two years.

It is clear then that a combination of biological, psychological and social factors may make D vulnerable to mental illness. The team around D have observed the following behaviours which can be compared to some of the 'warning signs' set out by Perry et al (2001):

- Loss of enjoyment in activities - D enjoys computer-based activities. However, at times of distress he loses interest very quickly.
- Fear and agitation – D exhibits extreme agitation and is fearful of some other pupils and staff.
- Loss of established skills – D's letter and number recognition is good, but he loses concentration on these activities at times of distress.
- Appearing to listen to or watch something which is not obvious to others – this is something which has been observed by D's support staff
- Onset of self-injurious behaviour – When distressed D can bang his head against walls and windows.
- Aggression - D has been known to hit, kick and bite other pupils and members of staff.

As the conclusion to this case study I asked the learning support assistant who works closest to D to maintain a 'high level of suspicion' (Royal College of Psychiatrists, 2001) for a number of days, at the end of which I asked her if she suspected that 'D' might have co-occurring mental health issues. She replied as follows:

I think he shows all the signs of anxiety. When he is in a crisis he just runs…looking for food. He eats everything he can find, even things he wouldn't eat normally. He's so tense you can see the muscles in his neck, and his heart goes really fast.

In an illustrative case study such as this, it is important to avoid pathologising what might be simply reactive behaviours to certain situations. However, in terms of D's vulnerability to mental illness, and taking into account his observable behaviours as well as information from his support staff, it is reasonable to conclude that D may be experiencing significant psychological distress. In line with the findings of the literature review, it may be that diagnostic overshadowing and other factors related to his care and primary diagnosis may mean that these issues are as yet undiagnosed.

CONCLUSION

At the beginning of this Special Study I said that I intended to answer the following questions: *What do teachers need to know about the mental health needs of their pupils with PMLD and why?* With respect to the 6 key issues I identified, I can now present a very brief summary of the answers to that research question.

The incidence of mental illness compared to the general population
Teachers need to know that there is a far higher incidence of mental illness in young people with learning difficulties than in the general population. The incidence in young people with profound and multiple learning difficulties is higher still.

Vulnerability to mental illness.
People with learning difficulties are at least as vulnerable to mental illness as anyone else, and the incidence statistics suggest that they may actually be significantly more vulnerable. Vulnerability is increased because of a complex interaction of biological, social, psychological, genetic and environmental factors

Issues with the diagnosis of mental illness.
Communication problems as well as issues of 'diagnostic overshadowing' make the diagnosis of mental health problems in young people with learning difficulties particularly problematic. Atypical symptoms such as challenging behaviour may be wrongly attributed to the primary diagnosis. In some cases, the classification of mental illness and the classification of a learning difficulty create ambiguities which impact on diagnosis.

Issues with treatment of mental illness.
Issues with treatment overlap with issues of diagnosis. In addition, there is a low usage of GP services, a lack of training for professionals, an overreliance on medication and a lack of understanding of the treatment needs of people with complex needs.

The impact of mental illness on families and carers.
Despite a relative lack of research evidence, it is clear that co-occurring mental health issues have a significant and debilitating effect on the families and carers of young people with complex needs. This is particularly the case where the psychological condition manifests itself in challenging behaviour, or when the carers themselves experience significant levels of stress.

Ways of promoting mental well-being within special schools.
In answering the question, *why* do teachers need to know the above, we are reminded that schools occupy a key role in protecting the mental health of all children (*Mental Health and Behaviour in Schools,* 2014*).*

A person-centred approach is important, as well as working with parents and carers, and ensuring that a regular and consistent staff team around the young person make him or her feel valued and has a sense of belonging to the school community. Professional development for staff as well as clear systems of identification, intervention and referral are also essential.

In Appendix 3 below, I present an extended version of the above in the form of a brief guide to mental health and learning difficulties for limited distribution to the teaching staff in my own special school.

It is also important in this conclusion to address briefly limitations presented by my research methods.

The questionnaire (Appendix 1) which was the basis of my research and conclusions reached too small a cohort of teachers to test for wider statistical significance and in the future it will be important to extend that process of data collection to a greater number of schools.

Similarly, the case study of one pupil is significant only in as much as it is able to supply illustrative information. A far wider cohort of young people will need to be studied in order to reach any more reliable conclusions about vulnerability to mental illness in the target group.

Following discussion with the Head Teacher it was decided that the potential sensitivity of the subject matter made it inadvisable to distribute a questionnaire to parents (Appendix 2). This meant I was unable to gather further information relating to the impact of co-occurring mental health issues on families.

This has been an extremely interesting and rewarding study. It has pointed firmly to another reason why teachers need to know about mental health and learning difficulties, which is so that they can maintain a ‘high level of suspicion’ (Royal College of Psychiatrists, 2001) with regard to the mental health of the target group.

However, this study is not a diagnostic tool and it is important to see it simply as suggesting a number of important issues which may merit further research and development.

Above all, this study has shown that until greater clarification of the relationship between special educational needs and mental health is achieved, young people with complex needs in particular will continue to struggle to have their needs met, with a significant negative impact not only for themselves, but also for their families, carers, teachers and support staff.

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APPENDIX 1

University of Birmingham, Department of Education
Andrew Colley, Student Number: 1394298
Masters in Education (SLD / PMLD)

CONFIDENTIAL TEACHER QUESTIONNAIRE

As my Special Studies module towards the Masters in Education, I am conducting research into the mental health of young people with learning difficulties, with particular reference to those with profound and multiple learning difficulties.
The purpose of this questionnaire is primarily to allow me to compare the incidence of diagnosed and suspected mental health problems in this school with National Statistics for those with and without special needs.
This is a confidential questionnaire, so please do not add your name, the names of any of your pupils or the name of your class. All questionnaires will be shredded once the data collected has been analysed.
Please note also that this questionnaire is not asking you identify or reveal mental health problems in your pupils. Questions 1 – 4 are purely numerical, and questions 5 and 6 call for a brief and very general reflection on this issue. **Many thanks**.

Please answer the following questions, with reference to your class only.

1) **How many pupils are in your class?**

2) **Of these, how many do you think are classified as having Mild, Moderate, Severe, and profound and multiple learning difficulties?**
   MILD:
   MODERATE:
   SEVERE:
   PMLD:
   OTHER CLASSIFICATION:

3) **Of the total number of pupils in your class (Qu. 1) , how many do you know have a diagnosed mental health condition, such as anxiety, depression, OCD, schizophrenia, ADHD, in addition to their primary diagnosis? Please then try to calculate that number according to classifications in Question 2.**
   TOTAL NUMBER WITH AN ADDITIONAL DIAGNOSED MENTAL HEALTH CONDITION:
   MILD:
   MODERATE:
   SEVERE:

PMLD:
OTHER CLASSIFICATION:

4) **Of the <u>total</u> number of pupils in your class (Qu. 1) , how many do you <u>suspect</u> have an <u>undiagnosed</u> mental health condition, in addition to their primary diagnosis? Please then try to calculate that number according to classifications in Question 2.**
TOTAL NUMBER WITH A SUSPECTED BUT UNDIAGNOSED MENTAL HEALTH CONDITION:
MILD:
MODERATE:
SEVERE:
PMLD:
OTHER CLASSIFICATION:

5) **In very general terms, what do you think the impact of additional mental health problems has had on your pupils and their families and carers?**

6) **In what ways do you think we as teachers can actively promote and maintain good mental health in our pupils?**

APPENDIX 2

University of Birmingham, Department of Education
Andrew Colley, Student Number: 1394298
Masters in Education (SLD / PMLD)

CONFIDENTIAL PARENT / CARER QUESTIONNAIRE (Unused)

As the Special Studies module as part of my Masters in Education, I am conducting research into the mental health of young people with learning difficulties.
The purpose of this questionnaire is to allow me to compare the incidence of diagnosed and suspected mental health problems with National Statistics for those with and without special needs.

This is a confidential questionnaire, so please do not add your name, or the name of your child.

All questionnaires will be shredded once the data collected has been analysed.

Please answer the following questions:

1) **Has your child ever been diagnosed with a mental health condition such as anxiety or depression? Please note: a YES / NO answer will be fine. You are not expected to reveal details unless you specifically want to.**
   YES / NO

2) **If the answer to Question 1 was yes, do you think that condition was diagnosed in a timely and accurate way?**
   YES / NO

3) **Do you think treatment was timely, appropriate and effective?**
   YES / NO

4) **If the answer to Question 1 was no, have you ever suspected that your child may have or have had an undiagnosed mental health condition such as anxiety and depression?**
   YES / NO

5) **Have you ever discussed the possibility that your child might have a mental health issue with his or her GP or any other professional involved in his or her care and education?**
   YES / NO

Many thanks

APPENDIX 3

University of Birmingham, Department of Education
Andrew Colley, Student Number: 1394298
Masters in Education (SLD / PMLD)

Mental Health and Learning Difficulties
A Short Guide

For my second year Special Study towards my Masters in Education, I chose to address the question: *What do teachers need to know about the mental health needs of their pupils and why?* As part of this assignment I have put together this short guide to mental health and learning difficulties which summarises some of the findings of my 8000 word Special Study. If anyone would like to read the full study, or would like a list of references, please contact me on: awcolley@outlook.com

For the purposes of this guide, the term 'mental illness' refers to levels of emotional, psychological or psychiatric distress that present significant challenges for young people, their families and those who support them. This includes the following types of disorder:

- Non-affective disorders (i.e. not effected by emotions and moods) such as schizophrenia
- Affective disorders (i.e. disorders linked to mood or emotion) such as depression and anxiety.
- Neurotic and stress-related disorders and phobias such as OCD and agoraphobia
- Eating disorders such as anorexia nervosa
- Hyperkinetic disorders such as ADHD
- Conduct Disorders such as self-injurious behaviour (SIB)

It is also important not only to talk about 'mental illness', but also mental health or 'mental well-being' which has been defined by the World Health Organisation (2010) as '*a state of mind in which an individual is able to realise his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her own community*'.

The incidence of mental illness in young people with learning difficulties compared to the general population.

A number of recent studies agree that the rate of all mental illness in people with all levels of learning difficulty is about 40% compared to around 10% for the general population. The rate of mental illness in people with more complex needs has been shown to be even higher.

People with learning difficulties suffer from the same types of psychiatric disorders as the general population though not necessarily in the same proportions. For example, children with learning difficulties are 8 times more likely to have ADHD than those without learning

difficulties, 6 times more likely to have a conduct disorder, 4 times more likely to have an emotional disorder, 3 times more likely to experience schizophrenia, and 1.17 times more likely to have a depressive disorder.

Some types of learning difficulty are more prone to certain forms of mental illness. Depression is common in people with Down's syndrome, and mania, anxiety and distinctive or unusual patterns of eating often present in people with autism. People with Williams Syndrome and Fragile X can show a high incidence of a range of mental health issues, and young people with complex needs often exhibit Self Injurious Behaviour.

Vulnerability to mental illness

People with learning difficulties are at least as vulnerable to mental illness as anyone else, and the incidence statistics quoted above suggest that they may actually be significantly more vulnerable.

Mental illness in all groups is usually caused by a combination of biological, genetic and environmental factors, and in people with learning difficulties we also have to take into account a very complex interaction of often multiple biological, psychological, social and family factors as well.

Medical and psychiatric conditions often occur together, with internal triggers such as pain, physical illness and puberty leading to psychiatric distress especially where the patient struggles to express or describe that pain. Epilepsy, which is found in 1% of the general population and up to 60% of people with complex needs is commonly associated with co-occurring psychiatric disorders.

Other significant psychological and environmental factors which can create vulnerability to mental illness and are commonly experienced by people with learning difficulties include:

- Feeling trapped or humiliated
- Bereavement
- The loss of a carer, friend or pet
- Placement changes
- Parental separation
- Attachment disorders
- Lack of intimacy
- Social isolation
- Exclusion
- Inactivity
- Institutionalisation

Poverty impacts significantly on mental health and is frequent in families of people with learning difficulties and in particular those with complex needs. It has been estimated that 57% of young people with learning difficulties and mental health issues live below the poverty line, 30% live in the top 20% of Britain's most deprived areas, and 40% are being brought up by a lone parent.

Issues with Diagnosis

There are considerable difficulties with the diagnosis of psychiatric or psychological problems in young people with learning difficulties and in particular in those with complex needs, and as a result these types of problems often go unrecognised and untreated. 'Diagnostic overshadowing' means that often clear signs of a psychiatric disorder are inappropriately attributed to a person's learning difficulty and are not seen as resulting from mental health needs.

The most widely used classification manuals for mental illness – the Diagnostic and Statistical Manuals (DSM) and the International Classification of Diseases (ICD) may not be applicable to the experiences of people with learning difficulties as these manuals tend to classify mental health problems as changes from normal, whereas symptoms in people with learning difficulties may not have changed for years. Another issue preventing accurate diagnosis is that diagnostic criteria are predicated on their use by the general population and weighted towards verbal items. A patient normally will be required to communicate verbally his or her distress. This is not always possible with someone with learning difficulties.

Psychiatric disorders such as depression and anxiety can present atypically as behavioural problems including aggression or self-injurious behaviour. Accurate diagnosis will therefore depend on being able to identify which behaviours may be a direct consequence of the learning difficulty and which are not. As practitioners, it is important to challenge the assumption that unusual behaviour is attention-seeking or 'deliberate' and consider whether there may be an underlying mental health component.

Diagnosis of course can and should only be carried out by a doctor. However, teachers are well placed to maintain what the Royal College of Psychiatrists (2001) call 'a high level of suspicion'. Warning signs of a co-occurring mental health issue in someone with learning difficulties can include loss of enjoyment in activities; fear and agitation out in the community; loss of established skills; increase or decrease in vocalisation; appearing to listen to or watch something which is not obvious to others; onset of self-injurious behaviour, aggression, and changes in sleep pattern. Accurate and timely diagnosis also depends on maintaining good communication between family, carers and members of the multi-disciplinary team.

Issues with Treatment

There is a high incidence of mental health issues in people with learning difficulties, but there is at the same time a low utilisation of mental health services. Those requiring help often encounter difficulties in getting appropriate services, and pathways to referral for help and support can be vague. There are often long time delays to access assessment and treatment and young people with learning difficulties can be shunted between mainstream and specialist services. 'Therapeutic disdain' is a term which describes the relative lack of interest shown by professionals in the psychiatric problems of people with learning difficulties.

There are three main strands to the treatment of mental illness in the general population: biological, psychological and psychosocial / environmental, but only the first and third can be expected to be appropriate to many people with learning difficulties because issues with communication mean that 'talking therapies' can be less effective.

There can be an over reliance on psychotropic medications - which are prescribed to over 30% of people with learning difficulties - and a lack of knowledge about appropriate dosage or possible side effects for someone with learning difficulties, particular when taken at the same time as other essential medication.

Psychosocial and environmental treatment can be more useful and include modifications to school or living environments which impact on the young person.

Impact on Families

The parents and siblings of children with learning difficulties show an increase in anxiety and depression. Attachment disorders are also common as parents struggle to come to terms with having a child with special needs. The stress of caring can be an enormous burden *and* carers need assistance to find avenues of mutual support. Short term respite care and a range of other support can be vital for the families. The early identification and treatment of mental health problems leads to an improvement in their quality of life and that of their families and carers.

Supporting Mental Health

Schools occupy a key role in protecting the mental health of all children. An important key to promoting mental health in all young people is an understanding of the protective factors that enable them to be resilient when they encounter problems and challenges. The word 'resilience' describes the attributes of children who seem able to cope with difficulties, and although people with learning difficulties may seem to have less of this resilience, it is possible to foster a sense of self- esteem and confidence and a repertoire of problem solving approaches. A person-centred approach is important, getting to know the young person and their environment, working with parents and carers, and ensuring that a regular and consistent staff team around the young person make him or her feel valued and has a sense of belonging

to the school community. Professional development for staff as well as clear systems of identification, intervention and referral are also essential.