The Queen's Nursing Institute

Transition to the School Nursing Service

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Section B - Working in the community

Chapter 4: Supporting developmental needs across the lifespan

Introduction

In your role working with the School Nursing Team (SNT), developing an understanding of developmental milestones will help you with the key skills needed to deliver the Healthy Child Programme (HCP) 5-19 (DH, 2009). This will enable you to identify when children or young people need referrals to other agencies or when they will need more targeted support from the SNT. You will be involved in monitoring children and young people at transitional points in their lives: entering education, moving to secondary education, going through puberty or dealing with traumatic events in their lives.

The aim of this Chapter is to:

- Develop understanding of child and adolescent development
- Discuss what factors influence this development
- Explore the transition into adulthood
- Discuss the role of the school nurse in supporting developmental needs

It is important for school nurses to understand what 'normal' (sometimes termed typical) child development looks like and how to identify problems that may impact on children and young people achieving optimum health outcomes. This chapter explores the key areas of physical, cognitive, social and emotional development of children and young people and the factors that will impact on them. In particular the chapter will focus on:

- Developmental milestones
- Attachment theory and how this impacts on the development of relationships
- Understanding of adolescence
- Transitions: for example starting school or moving up to secondary school.

‘It is important for school nurses to understand what ‘normal’ child development looks like.’

A guide to some broad developmental milestones in the school years

Stage of development	Physical development	Cognitive development	Social and emotional development	Network of significant relationships	Coping strategies (adaptive qualities)
Early School Years KEY STAGE 1 (5-7)	-Growth - Approx: Girls - Weight: 12-32 kgs, Height: 100-134 cm Boys - 15-31 kgs, Height: 101-135cm -Gross and fine motor skills –e.g. hopping and writing. Able to walk heel to toe. -Bladder control - 85-90% 5-7 year olds dry by night	-Conversation developing clear to those outside usual contacts -Rate of vocabulary varies but may have 15,000 words, gaining 3000 per year -By 7 understands and uses conjunctions, tag questions, passive tense and infinitives. -Begins to see the world in terms of rules -Thinking generally related to specific experiences . -Beginning to use simple logic -By 7 able to categorise items, eg dinosaurs, football teams -Using number and learning to tell time -Has simple concepts of distance, time and speed.	-Gender identification – development of self -Early moral development -Peer play/making friends	-Family, culture, environment, school, friends.	-Development of inner processes such as reactions to crises - Resilience. -Developing a purpose and the courage to pursue personal goals
Middle childhood KEY STAGE 2 (7-11)	-Growth: Long bones and trunk lengthen. Start of puberty. -95% 10 years olds have bladder control but boys are over represented in those not dry by night	-Beginning to see and understand other’s points of view -Increasing complexity of language and number of words -Developing syntax (grammar), using and understanding conjunctions, tag questions, passive tenses and infinitives	-Friendships – peer influences -Skill learning -Self-evaluation -Team play	Family etc, school, wider environment, teachers, friends	-School rules and boundaries -Family beliefs etc -Self esteem -Developing understanding and competence - skills and knowledge
Adolescence KEY STAGE 3 (11-14) KEY STAGE 4 (14-16)	Adolescent brain development	-Able to think in abstract terms -Sees others points of views -Hold strong beliefs	-Emotional development -Membership of peer group, peer pressure	-Peers, family, school, teachers, environment	-Boundaries/respect for parents and society as a whole

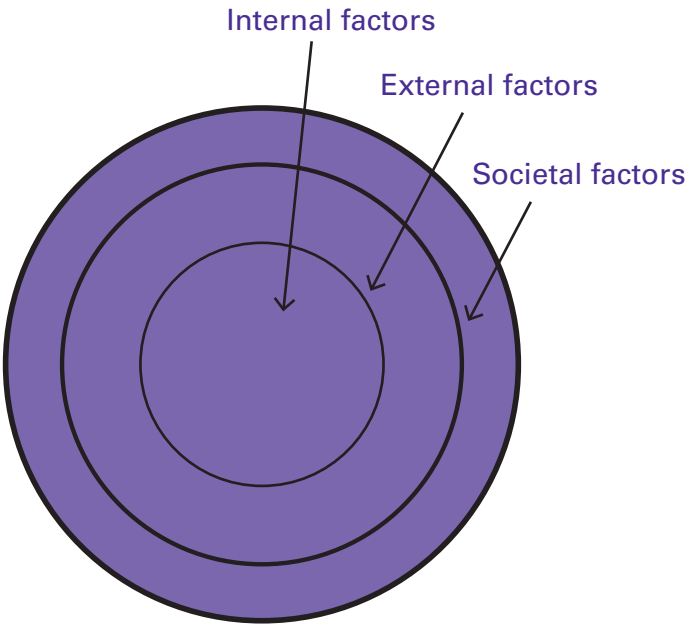
A guide to some broad developmental milestones in the school years

Stage of development	Physical development	Cognitive development	Social and emotional development	Network of significant relationships	Coping strategies (adaptive qualities)
Adolescence CONT. KEY STAGE 3 (11-14) KEY STAGE 4 (14-16)	Girls: -Commencement of Puberty: 8.5-12.5 years of age. -Oestrogen stimulates growth and development of reproductive organs -Breast development -Growth of pubic and axillary hair -Rapid growth in height -First menstruation approximately 2.5 years after start of puberty Boys: -Commencement of Puberty 10-14.5 years of age. -Androgens, largely testosterone, stimulate growth and development of the reproductive organs -Testicular enlargement and growth in length and girth of penis -Change in voice with lowering of pitch of voice -Growth in height later and more marked than in girls -Hair growth in pubic, axillary face and chest areas		-Romance and sexual relationships -Mood swings in evidence possibly as result of hormones or of different and changing expectations -Confidence develops and becoming more independent -Developing own identity separate from family - Friendship based on intimacy		-Developing drive and ambition, setting own goals -Developing relationships and loyalty to others
Young adulthood (18-24)	-Continued physical maturation -Brain development -Possible changes to sleeping patterns	-Able to think in abstract terms -Sees others' points of views -Hold strong beliefs	-Autonomy from parents -Gender identity -Internalised morality -Career choice	-Society, friends, work, college, culture, social class etc	Personality, personal experiences of, for example bullying. -Ability to find work etc -Develop own, individual values and beliefs, may or may not be related to parents/ family

Reference: Adapted from Thurtle and Wright (2008)

‘One of your key roles will be to help support the transition of children into school.’

Think about the factors that will affect these expected developmental milestones with your mentor and fill in the chart below:



Some internal factors:

- Genetic factors (for example the impact of disability)
- Congenital factors
- Personality
- Temperament
- Internal motivation

Some external factors:

- Family relationships
- Family structure
- Position in the family
- Family expectations and encouragement
- Cultural factors
- Domestic abuse (both direct and observed)
- Individual circumstances (for example living in poverty)
- Substance use/misuse
- Community networks

Some societal factors:

- National and local health, social and education policy
- Societal attitudes to children and young people
- Community cohesion

The transition into school

One of your key roles as part of the SHT will be to help support the transition of children into school. This is a huge transition for children as they become more independent from their family and develop their learning potential as well as how to socialise with others. Working with other professionals will be important for you to support children entering the education system. In particular, good liaison with health visitors will help to ensure a seamless transition into school and help with school readiness.

See the pathway for the transition from the early years to school: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216466/dh_133020.pdf

Many children now attend early years’ settings before school and so have developed some of their social skills. The education system at five however, does put more pressure on learning and achieving in a more structured way. Children are also expected to learn how to behave appropriately to be able to ‘fit in’. An awareness of factors that will impact on learning, social and emotional development is important.

One aspect of physical development that you may encounter in the primary school is continence (soiling and enuresis). Most children will be dry during the day when they enter school but some may be wetting at night and this will cause concern for some parents and they may ask you for help. You will need to be aware of local services and the SHT team may be involved in clinics or other models of treatment and care. Some general, initial advice that you could give (from ERIC (Education and Resources to Improving Childhood Continence) includes:

Take a history of the bed-wetting - for example is it a new problem/is the child unwell; if not:

- Talk to parents about fluid intake and bedtime routine. Fluid should be encouraged rather than reduced.
- Lifting a child to the toilet when they are asleep is not recommended: an alarm is needed to wake them up.
- Emphasise that bed-wetting is not the child’s fault and encourage parents/carers to avoid punishing the child
- A reward system could be tried with care.

If this advice is not sufficient then ERIC/NICE guidance suggests:

- An alarm
- Desmopressin
- Alarm and desmopressin.

You will need to explore the ERIC website for more information about enuresis and also about other continence issues such as constipation or soiling www.eric.org.uk.

NICE guidance: www.nice.org.uk/guidance/cg111

The importance of early attachment

Attachment can be defined as: 'an affectional tie that one person or animal forms between themselves and another specific one – a tie that binds them together in space and endures over time.' (Ainsworth 1969)

Evidence suggests that early attachment to a main carer has a positive long term effect on healthy adult relationships. This is sometimes referred to as social and emotional competence or emotional intelligence. Emotional intelligence enables individuals to understand their own emotions and those of others, which help them to develop empathy. This is important for socialisation – those who cannot display empathy are more likely to become socially isolated, find it difficult to make friends and later this may lead to violent crime. Attachment, along with other factors also impacts on the development of resilience. Resilience is associated with the ability to cope with change in our lives. Individuals who have good resilience are likely to cope with traumatic events better than those who don't.

Discussion point: discuss with your mentor/find out about the different types of attachment: secure, avoidant, ambivalent or disorganised.

The SHT should be made aware of children who may be displaying signs of poor attachment. The reasons for poor attachment may include:

- Mothers who have experienced post natal depression
- Neglectful relationships
- The 'toxic trio': domestic violence, substance misuse and mental ill health

It is very important to ensure that you don't make assumptions about perceived 'attachment disorders behaviours'. There may be other explanations for some of these behaviours such as Attention Deficit Hyperactivity Disorder, Autistic Spectrum disorders, parenting issues or a traumatic event in the child or young person's life. Behaviours identified by you, teachers or others should be carefully assessed by the most appropriate professional to ensure that parents do not feel 'blamed' for their child's behaviour. Discuss referral routes in your areas with your mentor.

Potential signs of poor/insecure attachment

Early signs - possibly at school entry or soon after:

- Being either very clingy or appearing distant and independent with adults
- Alienation/opposition to parents/carers
- A low self esteem
- Difficulty in making friends (may be antisocial behaviour)
- Lacking self-control (maybe becoming angry or aggressive)
- Some speech and language problems
- A lack of empathy
- Difficulty in concentrating/sitting still or learning

'Helping parents to think about how they manage their child's behaviour may be a part of your role.'

Possible later signs in childhood/adolescence or young adulthood:

- Antisocial behaviour/violence/crime
- Lack of empathy
- A lack of self-control
- Difficulty in dealing with stress or adversity
- Isolation
- Depression

The SHT will need to engage parents/carers in the process of intervention to gain their trust and ensure that the most appropriate plan is in place for the child or young person. It may be that parents/carers have their own concerns as well; one indicator of problems may be if the behaviour is the same in any setting that the child or young person is in. Sometimes, children and young people behave appropriately in school but not at home and parents/carers might seek your help.

Helping parents to think about how they manage their child's behaviour may be a part of your role. You may be involved in a number of ways: you could work one to one with a parent if appropriate, you could help run a parenting group or you might need to refer on to other services such as CAMHS. There may also be other support groups in the area for parents; find out what is available in your area and discuss your role with your mentor.

Attachment is an important area for you to think about and you can do more reading on this. Here are some good resources for you to access:

Why Love Matters: http://www.ecswe.net/downloads/publications/QOC-VII/Chapter3-Why-Love-Matters-How-Affection-Shapes-a-Babys-Brain-by-Sue-Gerhardt.pdf

Herbert M (2005) Developmental problems of childhood and adolescence; prevention, treatment and training Oxford, Blackwell

There are also some good novels which highlight some of the issues around attachment issues but also other behavioural problems in childhood and adolescence:

Haddon M (2003) The Curious Incident of the Dog in the Night Time London, Doubleday

Shriver L (2005) We Need To Talk About Kevin London, Serpents Tail

Filer N (2013) The Shock of the Fall London, Harper Collins

The table below summarises the key messages about attachment through the developmental stages:

Childhood stage	Social/ emotional compe-tence	Intellectual develop-ment	Behaviour-al compe-tence
Infancy	Trust/attach-ment	Alertness/ curiosity	Impulse and control
Toddler	Empathy	Communi-cation Motivation	Coping
Childhood	Social rela-tionships	Reasoning/ problem solving	Goal direct-ed learning
Adoles-cence	Supportive networks	Learn-ing abil-ity/achieve-ment	Social re-sponsability

Supporting the transition into adulthood

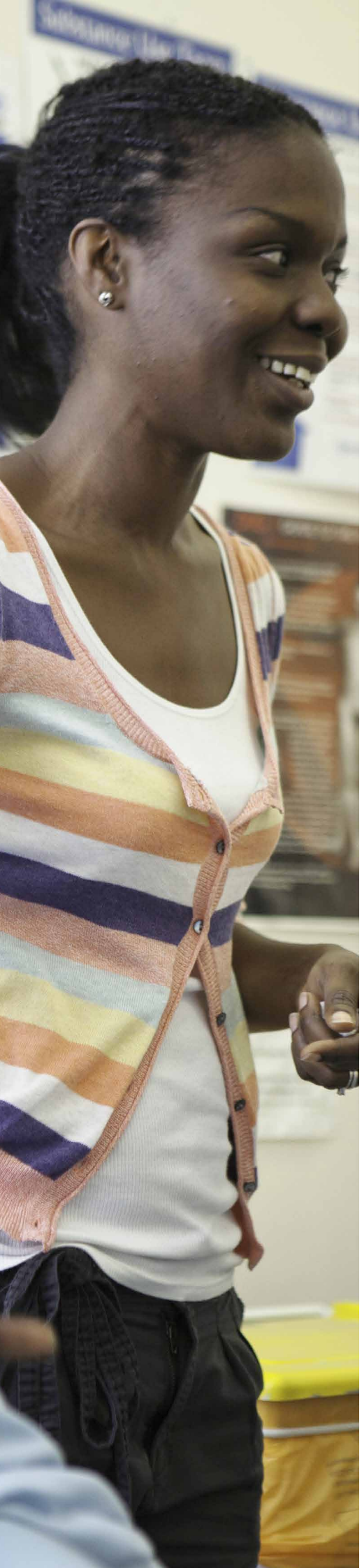
You may also be involved in supporting young people with their transition into secondary education from the primary sector and also into adulthood. Young people moving to secondary school aged 11 may be entering puberty, which may be a particularly difficult time for them physically and emotionally. They may be dealing with:

- Changing body shape/physical changes
- Mood changes
- Building relationships and exploring sexuality
- Becoming an adult/developing independence
- Preparing for life/career
- Developing a personal value system
- Forming a clear identity
- Achieving financial and social independence

Reflection point: Think back to when you were a teenager and what you were like. What things helped you cope, what support did you get, how did you behave, did you rebel, how did you dress?

The impact of these changes will be influenced by many things:

- Brain development
- Hormonal changes
- Peer pressure



- Family circumstances and expectations
- Cultural expectations
- Societal/educational expectations or pressure
- Particular circumstances such as additional health or social needs which may lead to vulnerability. For example young people with learning difficulties, physical disabilities, medical conditions, and young people looked after by the local authority or in other poor social circumstances.

These changes and influences to them may lead to particular behaviours in adolescence:

- Taking risks (smoking, alcohol and drugs)
- Low self esteem
- Being bullied or becoming a bully
- Self-harming behaviours
- Unhealthy sexual relationships (child sexual exploitation for example)
- Depression
- Eating disorders such as anorexia nervosa

Early identification and intervention is important for all those working with young people as they progress through to adulthood. Their needs to be an integrated, targeted approach which is built on a trusting relationship. You may have already worked with children in the primary school sector and identified that some need extra support. Many schools have transitional processes in place with their feeder schools and you may need to share information with others in order to best support the move to secondary education. Close working relationships between school staff and school nurses is the key to supporting young people. Discuss with your mentor and the SHT and identify what your role might be within the team in secondary school education.

Understanding some teenage behaviours

Recent research (NIMH 2015) suggests that much of the behaviour typically associated with teenagers can be explained by the ongoing development of the teenage brain; two examples of which are:

1. **Sleep** - Changing sleeping patterns are common in teenagers and there is some evidence to suggest that this is related to changes in the brain. It has been argued that the change is related to the release of melatonin which is needed to induce sleep. Studies of adolescents would suggest that melatonin starts to be released much later during adolescence (around 11pm) than previously and continues through the night, into the morning (The Sleep Foundation 2015). This might explain their sleepiness in the mornings and reluctance to get out of bed. The Sleep Foundations suggests that teenagers need between 8-10 hours of sleep each night but that only about 15% of them get that amount of sleep. Sleep is important for general health and wellbeing; it allows the body to regenerate and grow and it is also important in terms of your ability to learn, listen, concentrate and solve problems. Changing school timetables has been suggested to accommodate adolescents and their changing sleep patterns and brain development. You can find out more about sleep at: http://sleepfoundation.org/

2. **Risk taking** - Adolescents have a reputation for taking risks. This may be associated with smoking, drinking or taking drugs or it may be related to high adrenaline fuelled activities such as driving

too fast in the later adolescent years. It may be associated as well with more complex risk taking such as self-harming behaviours which may involve cutting or, it could be argued, eating disorders such as anorexia nervosa. These are difficult problems to cope with and may require specialised mental health services such as Child Adult Mental Health Services. You need to be aware of some of the signs of mental health problems such as these and they can begin with an overall change in behaviour noted in school or the home.

Some signs might be:

- A low self-esteem
- Becoming withdrawn or secretive
- A lack of interest in school where there was enthusiasm before
- Falling academic achievements
- Signs of clinical depression

It will be important for you to be familiar with the referral routes and the tier system within CAMHS. Talk to your mentor about what your role might be in this system:

Tier one

CAMHS at this level are provided by practitioners who are not mental health specialists working in universal services; this includes GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies.
Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

Tier two

Practitioners at this level tend to be CAMHS specialists working in community and primary care settings in a uni-disciplinary way (although many will also work as part of Tier 3 services).
For example, this can include primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services.

Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

Tier three

This is usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders.

Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

Tier four

These are essential tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.

Self-harming behaviour may be considered as risky and the following guidance is from NICE:

1. Assess immediate risk of physical harm - refer to hospital if necessary/call an ambulance/police.
2. Consider the mental health and emotional state of the young person - Identify the main demographic and clinical features and psychological characteristics such as depression, hopelessness or ongoing suicidal tendencies.
3. Treat people with respect, care and privacy.
4. Show compassion and understanding.
5. Assessment needs to include an exploration of the individuals feeling and thoughts about the self-harming behaviour.
6. Explore other coping strategies.
7. Involve young people in any decisions that are made about their care.
8. A psychosocial assessment should be made - this includes background, family, friends, ambitions etc.
9. Support the family or friends if appropriate.
10. Effective collaboration with other services.
11. Staff should have regular clinical supervision.
12. Consider issues around consent and mental capacity.
13. Harm minimisation strategies: reduce the risks for young people if they continue to self-harm; clean equipment for example.

The following websites provide some helpful information for young people and school nurses:
www.nice.org.uk/guidance/cg16
www.thesite.org/mental-health/self-harm
www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm

One of the explanations of risk taking in adolescence is thought to be related to brain development. It is suggested by imaging techniques that the brain is still 'hard wiring' until late adolescence and that the last part of the brain to develop is the frontal lobe where the centres related to decision making are situated.

You can find out more about brain development at:
www.pbs.org/wgbh/pages/frontline/shows/teenbrain/interviews/giedd.html#ixzz1b1o577uc

Parents may access the SHT when they have teenagers that seem to change their behaviour overnight. Managing the anxieties of parents may be part of your role and helping them to understand what might be happening to their young adolescent will help them to cope more effectively. Maintaining good boundaries with teenagers and guiding them towards independence while continuing to keep them safe can be difficult: it can be a very traumatic time for a family. Your area may offer parenting groups for parents of teenagers and it would be helpful for you to be involved in these.

Scenarios for discussion - think about what you might do in the following situations, how they can be related to child and adolescent development theory and then discuss them with your mentor:

1. Karl is five years old and has just started school. He is a quiet child and often withdrawn. He rarely speaks to adults and seems to have little language but he does form relationships with the other children. When you are doing the routine screening on school entry, he is slightly small for his age and the school expresses some concerns about him. These concerns are mainly related to his social and emotional development as he is meeting the educational milestones expected at his age.

What information would you need to obtain about Karl? Who would you contact and what would you do next?

Discuss this with your mentor.

2. On a routine screening check, Madeline (Maddy) who is five and has just started school, fails the hearing check and is also difficult to understand in terms of her speech.

What would you do next?

3. Charlie is five and in Reception class. The class teacher tells you that she is worried that sometimes he has difficulty getting up from the floor and when they are doing PE he sometimes loses his balance.

What explanations could there by for Charlie's problems and what would you do next?

4. Emily is 11 years old. You have weighed and measured her as part of the National Child Measurement Programme. She has grown significantly taller in the last 6 months and she also tells you that she is bigger than most of her friends. She feels that she has put on weight as well but her BMI is within normal limits. Emily appears very worried about the changes in her body shape.

How would you support Emily and what might be the issues that could occur for her?

5. You are doing an immunisation session in a secondary school. You notice that Kylie (15) has cuts on her arms and you suspect that they are self-inflicted.

What would your first action be?
Who might you talk to?
What referrals might you make?

Chapter summary

This chapter has explored some of the child and adolescent development theory that will assist you in your role and explain some of the behaviours that you might encounter. It has explored the support that you might consider for children going through transitions into school or to secondary school. It has helped you reflect on what skills and knowledge you might need to develop to further enhance your role in the school nursing team.

References

Some useful resources for further reading on these topics are:

Go to the link below for more information on common child development theories and theorists: http://lrrpublic.cli.det.nsw.edu.au/lrrSecure/Sites/LRRView/7401/documents/theories_outline.pdf

Boushel M, Fawcett M, Selwyn J (2000) Focus on early Childhood: principles and realities. Oxford, Blackwell Science.

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Thurtle V Wright J (eds) (2008) Promoting the Health of School Age Children London, Quay Books.