

New
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Heads up

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Mental health of children and young people

A guide for donors and charities



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Foundation

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Summary

What springs to mind when you think about mental health? If the answer is psychiatrists, straitjackets and medication, you are not alone. Many people see mental health problems as rare and frightening. They also tend to associate them with adult life rather than childhood—it is much easier to think of children and young people's problems in terms of moodiness, teenage angst or 'growing pains'.

The reality is that mental health problems are neither rare nor just a normal part of growing up. **One in ten children and young people has a diagnosable mental health disorder** that causes them misery and distress, and affects their ability to learn, make friends, cope with stress and enjoy day-to-day life. Problems such as depression and anxiety, eating disorders, self-harm and psychosis are more common than most of us realise and have a devastating impact on individuals, families, and communities.

Children do not just grow out of these problems. **Three years after being diagnosed, two thirds are still affected.** As children with mental health problems get older, they are more likely to struggle with relationships, truancy and exclusion from school, unstable employment, involvement in crime, and social exclusion—some of the most costly problems in our society. Given that most adults with mental health disorders had problems in childhood, it makes sense to act as early as possible.

Who is responsible?

Government policy has emphasised that children and young people's mental health is **'everybody's business'**. But the state—through health services, schools and social services—still does not have the resources to reach all children and young people who need help. More than 40% of children and young people with a disorder do not get any treatment. Services are oversubscribed and children and young people may be reluctant to seek help as they are ashamed of their problem or find services intimidating and inflexible. This leaves them isolated and scared.

As mental health is linked to many other social issues—child abuse, domestic violence, substance misuse and crime—it can be unclear who should take responsibility for an individual. Consequently, children and young people may be passed between services, or fall through the gaps.

How are charities helping?

Charities help to fill these gaps, by picking up hard-to-reach children and young people and providing the kind of support that they need—services that are accessible, sympathetic and responsive, and treat the individual as a person rather than a diagnosis.

As well as offering direct support, charities are also helping to develop the sector. With greater resources, charities have the potential to expand their work in:

- **Campaigning** to combat stigma, raise awareness of mental health problems, and push them up the political agenda.
- **Preventing problems**, or tackling them in the early stages, by developing programmes that improve parenting skills and support vulnerable groups.
- **Involving children and young people** in the development of services, to ensure that their needs are met.
- **Building the workforce** by training teachers, GPs, school nurses, and other frontline professionals so that problems are identified sooner.
- **Carrying out research and evaluation** to improve the evidence base and demonstrate what works in practice when it comes to preventing or treating specific disorders, and promoting good mental health.

What are the challenges?

The charity sector for children and young people's mental health is **small and under-resourced** relative to the scale of the problem. Although charities make a vital contribution to improving children

and young people's mental health, they tend to lack public profile. This limits their fundraising ability and means that the campaigning voice for child mental health issues is weak.

The sector is also **fragmented**: between the medical, education and social care professions, between different therapeutic approaches, and between different types of charities. This, combined with lack of resources, means that charities do not work together as effectively as they might.

What can donors do?

NPC has identified ways in which donors can make a very real difference to this growing sector. They may wish to target their funding towards specific conditions, local areas or vulnerable groups, such as young refugees, children who have suffered from neglect or abuse, or young offenders. Alternatively, more ambitious donors could support charities that help to strengthen the sector, for example by campaigning for policy change or tackling stigma. The choice they make will depend on the size of the donation and their appetite for risk.

NPC's recommendations

There is a wide range of opportunities for charities to really **champion the issues** and for donors to support **pioneering initiatives** that improve children and young people's mental health. Our research highlights the importance of positively promoting mental *health*, as well as tackling mental *illness*. Children with good mental health are more likely to overcome adversity and grow up into adults who can enjoy life and make a positive contribution to society.

New Philanthropy Capital is a charity that maximises the impact of donors and charities through independent research, tools for charities and advice for donors. We keep a list of **charity recommendations** covering mental health and other issues on our website at www.philanthropycapital.org.



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Introduction

Our mental health influences the way we see the world, the way we feel about ourselves, and the way we behave with others.

Our mental health influences the way we see the world, the way we feel about ourselves and the way we behave with others. If we have good mental health, we are more likely to enjoy life and realise our potential. Yet each of us will face situations that jeopardise our mental health and some of us may have to live with lasting mental illness. In these situations, we will need support to help us learn how to cope with our problems so that we can still live as full a life as possible. Without this support, we may struggle to stay afloat.

Here are two accounts of real children, describing the mental health problems they experienced and support they received. The names and some details have been changed to ensure anonymity.

Amy's story

By the time Amy was eight, it was clear to her teacher that there was something wrong. She seemed anxious and withdrawn in class, and the slightest thing would bring her to tears. On a little investigation, her teacher found that things were very difficult at home. Since an early age, Amy had witnessed frequent bouts of domestic violence, and both her parents drank heavily. It was no surprise that she was struggling to cope.

Amy's teacher brought this to the attention of social services, who referred her on to the local Child and Adolescent Mental Health Service (CAMHS). But no single service took responsibility for monitoring Amy's condition on an ongoing basis. By the time she was 12, her depression had got much worse and she had started to cut herself on a regular basis. Yet it was only when things reached crisis point and Amy tried to overdose on painkillers, that her case became a priority and she was admitted to an inpatient psychiatric unit.

Amy hated being in hospital. She was much younger than the others on the ward and physically very small. The degree of force that was used to restrain her when she tried to run away was very distressing, and the medication she was given made her sleepy and numb. Sometimes she was kept isolated in an empty, cold room by herself. Throughout this time, Amy did not go to school at all and rarely saw children her own age.

One source of relief and normality during her stay in hospital was provided by a local charity. Paul, a worker from the charity, regularly visited the ward where Amy was staying to run weekly groups and provide personal support. Paul looked at the children's non-medical needs and did not just talk about their mental health problems. His support helped Amy feel normal at a time when everyone else told her she was ill, and through the group she began to make friends on the ward.

However, when Amy returned home, her family problems were as bad as ever. Her parents were often drunk and violent, and Amy started to self-harm again. She began to starve herself and, at a particularly low moment, tried to throw herself in front of traffic. But despite her critical condition, it took nearly a month to find a bed for her, as the gastro and mental health departments argued over who would cover the costs.

After six months in hospital, Amy went back home. But the same old problems re-surfaced and she started to starve herself again. Although one therapist suggested that she should be removed from her family and taken into care, the local authority failed to follow this up. Meanwhile, Amy's weight was getting dangerously low. When she was told she would have to go back into hospital, she became very distressed and, the day before she was due to be re-admitted, she went out to a motorway bridge near her house and jumped to her death. She was only 14.

Luke's story

Ten-year-old Luke was the boy who always sat on his own at lunchtime. He had few friends, was sullen and disruptive in class, and frequently arrived at school late, if he turned up at all. Outside school, he had begun to hang out with older teenagers and had got involved in fire-setting and vandalism.

Luke could not look to his family for support. His mother had her own problems—she suffered from depression and panic attacks and was prone to drink heavily. His sister had been placed in care some years earlier, and his father, who was chronically ill, lived a long way away with a new partner.

One in ten children and young people has a diagnosable mental health disorder that will affect his or her ability to learn, make friends or enjoy normal life.

It was obvious to Luke's class teacher that he needed help. She referred him to The Place2Be, a charity that provides school-based counselling services to children and their families. Luke began weekly one-on-one sessions with one of the charity's counsellors, which took place in the school's special Place2Be room. Although he was unsure and cautious at first, and missed a few of his early sessions, he soon began to look forward to seeing his counsellor. For the first time in years, he was getting individual attention and having a chance to talk about his worries.

Luke's mother also started to take an interest and came into school twice to meet his counsellor. In the previous two years she had not even visited once. The Place2Be kept in regular touch with Luke's social worker and school staff, so everyone knew how he was doing. His teacher started to see visible improvements: *'Luke began to arrive at school on time every day,'* she noted, *'and dropped into The Place2Be on his way to class to announce that he was in. This in itself seemed to be a source of pride for him.'*

The case for support

Every year in the UK, millions of children and young people like Amy and Luke experience mental health problems. As their stories show, these can range from severe depression and self-harm to loneliness and antisocial behaviour. Though cases like Amy's are fortunately rare, problems that impair children and young people's day-to-day lives are surprisingly common. One in ten children and young people has a diagnosable mental health disorder that will affect his or her ability to learn, make friends, cope with stress or enjoy normal life.

And the problem is growing. Children and young people face increasing pressure to attain status in all spheres of life (education, social life, physical attractiveness) while having less and less family support and stability. They are also under more pressure as they make difficult decisions about sex, drugs and other life choices at ever younger ages.

Children will not just 'grow out' of these problems. Three years after being diagnosed with a mental health disorder, two thirds of children are still affected, and three quarters of adults with mental health disorders had a disorder in childhood. As children with mental health problems get older, they are likely to struggle with relationships, truancy and exclusion from school, unstable employment, involvement in crime, and social exclusion.

These problems have a huge impact on children, their families and communities, and on society more broadly. NPC estimates

that conduct disorder alone in children and young people costs society £1.5bn every year. This figure would be much higher if the costs were projected further into adulthood.

Chapter 1: The problem discusses these issues in detail.

What can be done?

The problem is clearly widespread and urgent, so what are the solutions and who is providing them?

Chapter 2: What works in improving mental health? gives an overview of the growing evidence for different ways of helping children and young people.

Unsurprisingly, the strongest evidence is for interventions that support children and young people with existing problems. However, more data is still needed about specific disorders and how to help people at a practical level. Charities and donors can address the gaps in the evidence base and demonstrate what works in practice by funding research and carefully evaluating the results of services they run.

The evidence for programmes that focus on the prevention of problems and the promotion of good mental health is more limited. This is not because these approaches do not work, but because more research is needed. Promising initiatives are being developed, particularly in terms of parenting skills. Charities and donors can make a big difference by funding, piloting and evaluating these.

Chapter 2 is by necessity technical. It would be easy to make 'motherhood and apple pie' statements about what is best for children growing up. However, understanding the research is necessary if we are to establish what works, what we think is promising but cannot prove, and what has been disproved.

Given that we are starting to understand what works, the next question is: does the situation on the ground reflect this?

Chapter 3: What is government doing?

explains the range of services and initiatives involved in promoting good mental health, and preventing and treating mental health problems. Services vary considerably from area to area, but under-funding, staff shortages and insufficient numbers of inpatient beds are common problems throughout the UK. Specialist Child and Adolescent Mental Health Services (CAMHS) are overstretched. They mainly focus on acute cases, and are not always accessible to young people.

Funding for national initiatives in schools is spread thinly, and schools determine whether

or not the initiatives are prioritised. *Sure Start*, the government's early years family support programme, is starting to show signs of improvement in child development. However, it is still in its infancy and the long-term benefits are not yet proven.

Charities can help to plug these gaps, support the hard to reach, and develop ways to help children and young people before they become acute cases.

Some readers may want to skip Chapter 3, as it focuses on policy and the details of government services. Other readers may find that they need this context in order to understand how charities and donors can best contribute to the sector.

How can charities and donors help?

Chapters 4 and 5 analyse the role of charities in this sector, the contribution that they make and the challenges that they—and donors—face.

Chapter 4: What are charities doing?

discusses the range of charities working in the sector. NPC's research revealed a sector that was thin in comparison to the scale and impact of the problem. This surprised us, until we understood that it is only recently that society has recognised the extent and implications of mental health disorders in children and young people. Mental health problems used to be regarded as rare and specialist and, although children's mental health is increasingly seen as 'everybody's business', resources do not yet match the need.

The main national charity for the mental health of children and young people, YoungMinds, has an annual income of less than £2m—much lower than the income of national charities in other sectors. The rest of the sector is fragmented between:

- small local charities, mostly helping teenagers and young adults;
- small charities focusing on specific conditions;
- a handful of charities working in schools;
- adult mental health charities with limited focus on children and young people; and
- large children's charities with a few projects specific to mental health issues.

One result of this fragmentation is that the campaigning voice of this sector is weak relative to other sectors, so achieving ambitious change is difficult. Options to fix big sector problems are limited, unless donors are prepared to make substantial and risky investments in the sector's infrastructure.

There are more opportunities for donors in direct service areas, such as working with families, schools, communities and specialist problems. But local and specialist charities are often small and high risk, and donors must be prepared for this.

Chapter 5: Challenges for charities and donors

looks at the issues relating to the structure and resources of the sector in more detail. Many organisations that NPC spoke to expressed concerns about changes to local funding and the difficulties of measuring results. This sector also has more marked professional and ideological divisions than other sectors that NPC has looked at. In broad terms, this relates to the split between 'medical' and 'social' approaches to mental health. But there are also divisions between voluntary and statutory services, health and education departments, and even between different therapeutic approaches.

Donors need to be aware of these challenges when thinking about how to support charities most effectively.

Wide-ranging solutions will help

When things go wrong, children and young people need sympathetic and responsive help. This was NPC's main area of focus, and so Chapter 4 discusses the contribution of charities that provide accessible, non-stigmatising services that treat the individual as a person rather than a diagnosis.

However, our research also threw up many opportunities for donors and charities to help prevent problems from developing in the first place. Some issues, such as poor parenting, substance abuse or youth offending, are so big and complex that NPC was unable to cover the topics comprehensively in this report. We have already researched several issues related to children and young people's mental health for previous reports: for example, truancy and exclusion, domestic violence, child abuse, and child refugees (see Table 1). It is likely that NPC will also undertake projects on caring for children, youth offending and substance abuse in 2009/2010.

Although children's mental health is increasingly seen as 'everybody's business', resources do not yet match the need.

Table 1: Relevant NPC reports

Subject	NPC Report
Adult mental health	<i>Don't mind me (2006)</i>
Autism	<i>A life less ordinary (2007)</i>
Child abuse	<i>Not seen and not heard (2007)</i>
Disabled children	<i>Ordinary lives (2005)</i>
Homelessness	<i>Lost property (2008)</i>
Parenting/caring for children	Forthcoming
Special educational needs	<i>Making sense of SEN (2004)</i>
Substance abuse	Forthcoming
Violence against women	<i>Hard knock life (2008)</i>
Young offenders	Forthcoming
Young people in divided communities	<i>Side by side (2004)</i>
Young refugees and asylum seekers	<i>A long way to go (2007)</i>

The experts that we consulted as part of our research also raised other, less obvious issues as possible avenues of exploration. These included diet and nutrition, and the effects of the media and internet on children. However, we failed to find much concrete action addressing these themes specifically in relation to children's mental health. We remain open to ideas and opportunities, and would encourage donors and charities to explore opportunities to solve the root causes of mental health problems, as well as tackling the obvious effects.

Finally, the range of funding options is discussed in **Chapter 6: Options for donors**. This helps donors to think through how they might prioritise the many different needs in the sector. It is a complex and challenging sector, but there are exciting opportunities for donors to make a difference at all levels:

- promoting good mental health in the general population;
- preventing mental health problems in those at risk;
- treating problems when they emerge;
- providing ongoing support to aid recovery; and
- improving the ability of the sector overall to campaign, provide training and conduct research.

There are exciting opportunities for donors to make a difference at all levels.

About NPC

New Philanthropy Capital (NPC) is a charity that maximises the impact of donors and charities. We do this through independent research, tools for charities and advice for donors. Our research guides donors on how best to support causes such as cancer, education and mental health. As well as highlighting the areas of greatest need, NPC identifies charities that could use donations to best effect. Using this research, we advise clients and their trusted advisors, and help them think through issues such as:

- Where is my support most needed and what results could it achieve?
- Which organisations could make the best use of my money?
- What is the best way to support these organisations?

NPC keeps a regularly updated list of charity recommendations on our website at www.philanthropycapital.org.

About this report

The need for this research was clear from NPC's previous report on adult mental health *Don't mind me*, which highlighted that many mental health problems experienced by adults have their roots in childhood and adolescence.

NPC started this project in February 2008. We have spoken to 50 experts, looked at 100 charities, visited or telephoned 40 of them, and received feedback on a draft of this report from eight consultative readers.

Scope

The scope of this report is limited as follows:

- In terms of geography, we covered England, Wales and Scotland, but not Northern Ireland. England is discussed in the most depth.
- In terms of disorders, we have not specifically covered learning disabilities and autistic spectrum disorders, because they were the subjects of previous NPC reports. Both are very important areas that are also inadequately served by government and charities.
- In terms of related issues, NPC plans to make parenting, substance abuse and youth offending the focus of future reports.

NPC has found that the terms 'children' and 'young people' are used to describe a broad age group, with no clear cut-off between the two. We have made similar use of these terms throughout the report. However, readers should note that when we discuss young people, we are talking collectively about adolescents and young adults up to the age of 25. This is because young people are often particularly vulnerable during the transition from adolescence to early adulthood, and mental health services for this age group are weak.

We also use the term 'donors' generically to refer to a broad group that includes individual donors, professional funders, grant-making

trusts, and corporate and family foundations. We specify when we are addressing a particular type of donor or funder.

This report is accompanied by ten charity recommendations, which can be downloaded from www.philanthropycapital.org. Some of them are not primarily 'mental health' charities, but make a significant contribution to improving the mental health of children and young people.

Appendices to the report are also published separately on NPC's website:
http://www.philanthropycapital.org/research/research_reports/health/child_mental_health_appendices.aspx.



Photograph supplied by The Place2Be



Photograph supplied by Kristian Buus

The problem

Mental health disorders affect one in ten children in the UK.⁶ This means that over a million children suffer serious psychological distress and experience problems with behaviour, learning, making friends, and coping with difficulties in day-to-day life.

These are much more than the normal ‘growing pains’ of childhood and adolescence. Problems such as anxiety, depression, eating disorders and self-harm cause misery and isolation for children and their families. As children with mental health problems grow up, they are also more likely to face problems with relationships, truancy and exclusion from school, unstable employment, and crime.²⁴

Donors and charities should be aware that, given the high long-term costs associated with mental ill health—for individuals, families and society—it makes sense to tackle problems as early as possible.

This chapter outlines what mental health means for children and young people. It describes who is affected by mental health problems, and why this matters.

Defining mental health

There is considerable ambiguity about what is meant by ‘mental health’ and ‘mental health problems’. This chapter describes what it means to be in good and poor mental health.

What is good mental health?

Good mental health is more than the absence of mental illness; it is a positive sense of well-being. For children and young people, it is the ability to learn, play, enjoy friendships and relationships, and deal with difficulties experienced during childhood, adolescence and early adulthood.

Normally, a child’s well-being is the result of healthy individual development within a sympathetic, nurturing environment. In the early years of life, infants make emotional attachments and form the first relationships that lay the foundations for future mental health.² Good early care provides a secure base from which the child can start exploring his or her environment. As the child grows, his or her emotional, cognitive and social development is

nurtured by good relationships with family, peers and community. The mentally healthy child should emerge from this with a clear sense of identity and self-worth, the ability to recognise and manage emotions, problem-solving and communication skills, motivation and a respect for the feelings of others.²

Mental health is therefore just as important as physical health. It influences how we feel, perceive, think, communicate and understand. Without good mental health, it is difficult for children and young people to fulfil their potential, or play an active part in everyday life.²⁵

What are mental health problems?

The term ‘mental health problem’ covers a wide range of experiences, from mild anxieties to serious and long-term illnesses. Some problems are relatively common, but may not be persistent. However, when these problems are severe, persistent and interfere with a young person’s day-to-day life, they may be diagnosed as ‘mental health disorders’.

For example, many young people experience low moods and feelings of depression. But there is a difference between ‘feeling depressed’ and ‘having a depressive disorder’.²⁶ Young people can feel low or upset by a particular event, such as the loss of a loved one. But they can usually overcome the feelings of sadness, grow from the experience, and move on with their lives. Young people who experience ‘clinical depression’ are dominated by feelings of such hopelessness and worthlessness that they find it hard to function normally. These feelings can last for long periods or recur in episodes.

In broad terms, it is useful to distinguish between:

- **Mental health problems:** a range of milder symptoms such as feeling unusually sad, worried or angry. These can be debilitating at times but will not usually be diagnosed for specialist treatment. They affect **20–30%** of children and young people.²⁷
- **Mental health disorders:** where behaviour or feelings are seriously outside the normal range. They impair day-to-day life and development, and cause significant suffering. Around **10%** of children and young people have a diagnosable disorder.⁶

Good mental health is more than the absence of mental illness; it is a positive sense of well-being.

Children want to be treated as individuals, not as medical diagnoses.

- **Mental illness:** severe forms of psychiatric disorder, particularly of the kind also found in adulthood, for example, schizophrenia, depressive disorders and obsessive disorders.²⁸ These affect **1–2%** of children and young people, and are more common in teenagers and young people than in young children.²⁹

The work of charities tends to focus on mental health problems and disorders, rather than severe illnesses, which are treated by specialist psychiatric services. However, charities can also play an important role in supporting children and young people while they are in hospital, giving them a chance to have fun and make friends, and helping them to recover and reintegrate into society after they leave inpatient care.

Box 1: Hyperkinetic disorder—a parent's perspective

*'He is all over the place—always on the move. He won't sit still at the table while we are eating—he's fidgeting the whole time, getting up between courses. He'd get up between mouthfuls if I let him. If there's a task that needs doing, whether it's homework or tidying his room, he'll start willingly but within a few minutes he's been distracted and begun doing something else instead. Sometimes, it is just an excuse and he never really wanted to do it anyway, but there are many times when I'm sure he couldn't help it. The teachers complain too, but I think they agree that it's the way he is made. Outside the family he is quite shy, and this keeps him a bit under control. But within the family, he has no inhibitions. He's forever interrupting, poking his nose in, acting without thinking of the consequences. At home, we try to make allowances, but there are still times when it leads to family rows—when he has yet again broken a pen or a remote control as a result of his ceaseless fidgeting, or when it's bedtime and he still hasn't finished homework that anyone else could have finished ages ago. At school, they can't make as many allowances as we can, and I think it has been stopping him doing as well as he should in his lessons.'*¹⁶

Source: Green, H., McGinnity, A., Meltzer, H., Ford, T. and Goodman, R., *Mental health of children and young people in Britain, 2004* (Office of National Statistics).

Box 2: Eating disorders

At least 1.1 million people in the UK are affected by an eating disorder. People of all ages suffer from eating disorders, but young people are especially vulnerable—80% of new diagnoses are for girls aged 14–20. Eating disorders have a higher mortality rate than any other psychiatric illness—one in five of those seriously affected will die. A person affected by an eating disorder is 200 times more likely to die by suicide than a member of the general public.³⁶

The earlier someone seeks help, the more likely he or she is to recover. However, it is incredibly difficult to identify, diagnose and treat someone with an eating disorder. This is because eating disorders are seen by the general public—and to some extent within medical services—as trivial, as 'silly girls on silly diets'. As a result, sufferers remain hidden and isolated, and do not seek the treatment they need. According to research from the charity beat, 92% of young sufferers felt that they could not tell anyone they had a problem.

Families, loved ones and friends are also seriously affected. Despite high levels of need, services for eating disorders are fragmented and patchy, and families often struggle to find advice and treatment. beat's research shows that only 12% of families affected by eating disorders get the support they need, and 79% suffer lasting damage.³⁷

Throughout this report, the term 'mental health problem' will be used generically to include all of the above, except when discussing specific disorders or illnesses.

Diagnosis and classification

Mental health problems are usually defined and classified by medical professionals. Classification is important for organising knowledge and research, and identifying symptoms. However, some diagnostic labels are controversial, and many can be stigmatising. Children and young people themselves want to be treated as individuals, not as medical diagnoses.

Labels can also confuse and intimidate people who are not from a medical background. Teachers may think that because terms such as 'hyperkinetic disorder' or 'obsessive compulsive disorder' are medical, the child must have some kind of concrete 'illness' with a genetic cause, and should only be treated by clinicians. However, whilst genetics may play a part, a whole range of family and social pressures may also contribute to a child or young person's mental health problem.³⁰

Diagnosis in children may be more difficult than in adults. Mental health problems in children often go undiagnosed, and therefore untreated, because the symptoms in children may be dismissed as normal childhood moodiness, bad behaviour or 'just a passing phase'. Children are also more likely than adults to show different symptoms depending on the situation.

So, while diagnostic labels provide a rough guide to understanding and treating a child's mental health problems, the reality is usually a good deal messier. A child or young person's experience will be shaped by a complicated history of influences that lead him or her to feel or behave in certain ways, and these do not always fit into neat diagnostic 'boxes'.

A brief overview of the most common mental health problems is listed in Table 2. Readers can turn to the Glossary for further details. Diagnoses alone do not indicate the severity of a condition, so they are often described as 'mild', 'moderate' or 'severe'.

Table 2: Different kinds of mental health disorder*

Condition	Prevalence	Symptoms and behaviour
Conduct disorders	6% of children aged 5–15 ⁶	Conduct disorders involve severe and persistent disobedience and defiance. Typical behaviour includes unusually frequent and severe temper tantrums beyond the age when they are normally seen, excessive levels of fighting and bullying, cruelty to others or animals, running away from home and criminal behaviour.
Emotional/ anxiety disorders	4% of children aged 5–15 ⁶	Emotional disorders include anxieties, phobias and depression. These problems can cause considerable distress. Symptoms of depression include sadness, irritability, loss of interest in activities, changes in appetite, sleep disturbance and tiredness, difficulty concentrating, feelings of guilt and worthlessness, and suicidal thoughts. Anxieties and phobias are related to fear, which can either be generalised or specific to a situation or object—for example, school or separation from a parent.
Hyperkinetic disorders	1.5% of children aged 5–15 ⁶	Hyperkinetic disorders prevent children from learning and playing as they should. They make children very overactive and restless, and can damage their relationships with other children and adults. Common symptoms include a short attention span, restlessness, being easily distracted, and constant fidgeting (see Box 1). Attention-deficit hyperactivity disorder (ADHD) and attention-deficit disorder (ADD) are also commonly-used terms for less severe hyperkinetic disorders.
Developmental disorders	1% of children aged 5–15 ⁶	Developmental disorders include autistic spectrum disorders and associated learning disabilities that typically affect a child's ability to communicate, learn, or interact with others. They usually affect children from an early age and persist into adulthood.
Eating disorders	1–2% of young women; 0.1% of young men ^{27, 34}	Anorexia nervosa, bulimia nervosa and binge eating are types of eating disorder. They are characterised by an abnormal attitude towards food, difficulty controlling how much is eaten, and making unhealthy choices about food that damage the body (see Box 2). The Glossary at the back of the report contains more information and prevalence figures on the different types of eating disorder.
Psychotic disorders	0.2% of 16–25 year olds ³⁵	Psychotic disorders cover a range of conditions where a person suffers from symptoms such as delusions and hallucinations. Schizophrenia can involve episodes during which reality is perceived differently. This might mean seeing or hearing things that others do not, or having delusions where people have unfounded beliefs (eg, that they are being persecuted or are famous). Bipolar disorder, also known as manic depression, is an illness that affects mood, causing a person to switch between feeling very low (depression) and very high (mania). In contrast to simple mood swings, each extreme episode may last for several weeks or longer. These conditions are rare and do not usually emerge until late adolescence.
Self-harm	6.7% of young people ³	Self-harm is not strictly a disorder in itself, but often the symptom of an underlying mental health problem. It is the way that some young people deal with psychological distress. It can include cutting, burning or poisoning oneself, and taking overdoses. Young people aged 11–24 are many times more likely to self-harm than any other age group (see Box 3).

* Definitions based on NHS Direct health encyclopaedia,³¹ British Medical Association guide for healthcare professionals,³² and National Institute for Clinical Excellence (NICE) guidelines.³³

Because parents provide children with their environments as well as with their genes, nature and nurture often act to reinforce one another.

What causes mental health problems?

Mental ill health can be caused by both genetic and environmental influences. Indeed, one expert points out that *'because parents provide children with their environments as well as with their genes, nature and nurture often act to reinforce one another'*.³⁹ The causes of mental health problems are complex, and there are a range of interrelating risks and triggers that will influence a child's development and mental health (see Figure 1).

Genetic causes are much stronger with some conditions than others. For example, later onset disorders such as schizophrenia and bipolar disorder are much more common in young people who have a parent with the disorder.

Individual risks include learning disabilities, specific developmental problems and communication difficulties, as well as low self-esteem and difficult temperament. Individual differences in biochemistry and sensitivity to diet can have an impact on physical and mental health development.⁴⁰

Family environment, and specifically the secure 'attachment' between child and carer, is arguably the single biggest determinant of a child's well-being (see Box 4). Childhood traumas such as bereavement or abuse make children extremely vulnerable. Parental conflict and neglect of the young child's emotional needs are associated with increased risk of mental health problems. Children whose parents separate, abuse drugs or alcohol, have a major financial crisis, get in trouble with the police, or suffer from serious mental illness are more likely to experience mental health problems.⁴¹ A recent study showed that children

of parents who separate are four times more likely to develop emotional disorders than those in families that stay together.²¹

Problems at school, such as exam stress, bullying and peer pressure, can trigger or increase mental distress. One expert claimed that a child with a genetic predisposition to mental health problems is five times more likely to develop these problems if he or she is bullied.⁴² In particular, depressive and suicidal thoughts are more frequent among young people who have been bullied and between 10 and 14 suicides are attributed to bullying every year.⁴³ In the playground, mental health problems are poorly understood and often stigmatised, which increases the sense of distress and isolation that sufferers feel (see Box 5).

Community environment plays an increasingly important role as children spend more time outside of the home and school. Safe places for play and constructive activities are vital for good mental health, while dangerous, divided and deprived surroundings undermine children and young people's sense of security and well-being. Substance abuse, crime and gang culture thrive where teenagers are disaffected and grow up with a lack of positive activities to engage them.

These factors contribute to poor mental health. Substance abuse, especially use of cannabis, but also alcohol and other drugs, is dangerous to developing brains. The number of under-25s admitted to hospital with mental and behavioural problems linked to illegal drug use has risen by 18% in the last decade.⁴⁴

Wider social influences also affect children and young people's mental health in ways that are subtle and hard to measure. Young people are under increased pressure as they make difficult decisions about sex, drugs and other life choices at ever younger ages. They face increasing pressure to attain status in all spheres of life (education, social life, sexual attractiveness) while having less and less family support and stability. Issues of identity can cause confusion and distress, and experts worry about commercial and media messages that raise expectations, resulting in young people being disappointed in life and in themselves.

Box 3: Self-harm

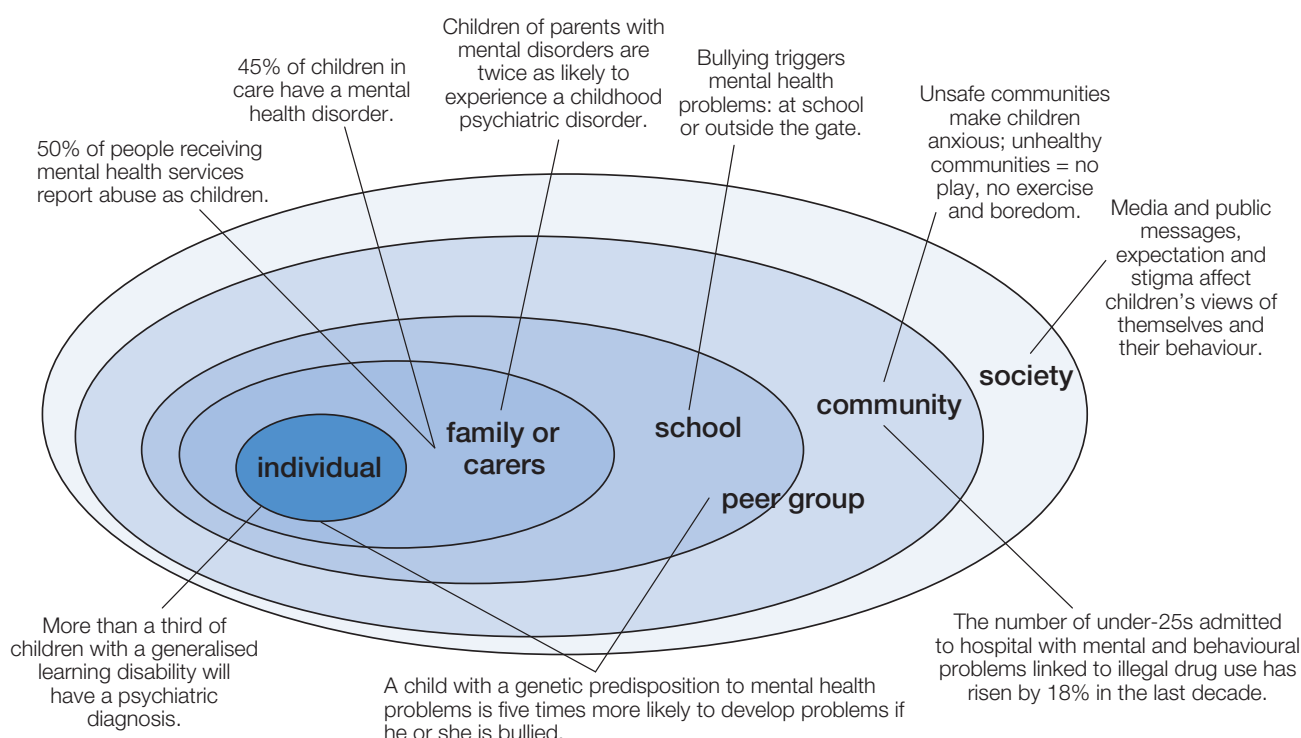
One in 15 young people in the UK between the ages of 11 and 15 years old has self-harmed.³ An estimated 25,000 young people a year in England and Wales end up in A&E as a result of self-harming.²

Young people describe many triggers for their self-harm. These are often daily stresses rather than significant changes or crises, and include things like feeling isolated, academic pressures, or the self-harming behaviour of someone close to them. Low self-esteem or poor body image can make young people feel unstable and hate themselves.³

Young people who self-harm are less able to cope when they are worried or upset. Instead of using positive coping methods such as talking to someone or trying to sort out the situation, they are more likely to resort to negative ways of coping, such as blaming themselves, cutting themselves, getting angry, staying in their room, or drinking alcohol.³⁸ In the words of one young person: *'Cutting for me releases all the built up anger and frustration and pain I feel inside.'* Another recalls: *'Sometimes when I felt numb and empty, scratching myself helped me to feel emotions again. Brought me back to life in a way.'* In many cases, what starts as a coping mechanism turns into an addiction.³

Figure 1: Risk factors associated with child mental health problems*

This diagram illustrates the influences on a child, and gives examples of the risks he or she might face. The most immediate influence is the family, which indicates how potentially damaging abusive parenting or a poor home life can be on a child. But it also indicates how a strong family environment can help protect a child from external risks at school, in the community and in society more broadly.



The influence of the media in children and young people's lives is pervasive but poorly understood. The use of television as an 'electronic babysitter' has been blamed for the rise of attention-deficit disorders.⁴⁵ Online, teenagers can find websites that provide tips on how to hide eating disorders or how deeply to cut themselves. A recent study found that people searching online for ways to kill themselves were more likely to come across sites encouraging them to take their own lives than those offering help.⁴⁶

There are physical and mental health concerns about children growing up with poor diets, limited exercise and few opportunities to play. On top of all this, young people are often vilified and presented as 'the problem' with modern society.

These factors are interrelated, and it is often very difficult to isolate single causes for mental health problems. As the leading child and adolescent psychiatrist, Professor Stephen Scott, explained in a discussion about conduct disorders:

'There's an interaction between your genetic predisposition and the way you turn out according to the way you're raised. When it comes to being antisocial, aggressive, stealing and lying, the interaction is a big one. If you have poor self-control and a rather twitchy, irritable

Box 4: Families at risk

A 2004 survey found that the prevalence of mental health disorders was greater among children in:

- Single-parent (16%) compared with two-parent families (8%).
- Reconstituted families, ie, families where the parents are no longer together and are now with other partners (14%) compared with families containing no stepchildren (9%).
- Families where the interviewed parent had no educational qualifications (17%) compared with those who had a degree-level qualification (4%).
- Families with a gross weekly household income of less than £100 (16%) compared with those with an income of £600 or more (5%).
- Families where neither parent worked (20%) compared with those in which both parents worked (8%).⁶

Children whose parents have a mental health problem are also at higher risk:

- Postnatal depression can cause a mother to become withdrawn or intrusive at a crucial stage of the child's development. Research also suggests that maternal depression can inhibit a child's relationship with his or her father, even if the father does not have a mental health problem.
- Children whose fathers had depression also have a 45% higher chance of developing depression themselves.^{16, 17}

It is estimated that two million children live in households where at least one parent has a mental health problem.¹⁶

At the time of going to print, the Office for National Statistics published an updated survey for 2004–2007. NPC has not had the chance to analyse this in detail, however it is likely to contain lots of data that is relevant to this section, and of interest for donors and charities. Readers can view the report at: www.statistics.gov.uk.²¹ NPC will publish a summary of the report in Appendix 4 on our website.

* All statistics are referenced elsewhere in the text.

Box 5: Stigma and ignorance

The distress of experiencing mental health problems is compounded by the fact that the subject of 'mental health' is stigmatised and poorly understood throughout society. In order to tackle mental health problems early, it is important that young people feel that they can speak out if they, or someone they know, is experiencing mental health problems. As one young person said: 'Self-harm is not tackled in schools or anywhere else. If they didn't make it such a dirty subject, people would come forward a lot more quickly to get help.'¹²

A recent survey by Great Ormond Street Hospital found that almost half of all school children could not name a single mental health condition. Most school children feel that they are not given enough information about mental health issues at school and prefer to trust the internet as a source of information. Girls aged 17 and 18 said that they were likely to find out about mental health issues from listening to celebrities talk about their problems. Great Ormond Street Hospital and a number of charities are developing resources and running campaigns to raise public awareness and combat stigma. These are discussed in Chapter 4.¹²

*temperament and you're brought up in a harsh way, it's bad news. For that group, the rate of criminality aged 17 is about 40%. But if you have that twitchy character and you're brought up in a reasonably calm, soothing way—your parents don't overreact, they let you run around in the park after school—you will do well ... It seems to be poverty of the parent-child experience ... that leads to poor child outcomes rather than poverty of a material kind.'*¹⁴⁷

When do mental health problems start?

With the exception of severe developmental disorders, normal psychiatric diagnoses are rarely made in pre-school children. However, the roots of mental health problems can sometimes be traced back to earliest infancy and even pre-birth. Poor maternal health—including mental health, nutrition, drug and alcohol consumption—is strongly linked to poor later outcomes for the child. For example, research suggests that Foetal Alcohol Syndrome, which affects between one and seven infants per thousand, is the 'most common known environmental cause of mental retardation', although some of the developmental damage may be as a result of poor parenting after birth.⁴⁸ Pregnancy and birth problems also increase the risks to the child's later mental health.⁴⁹

The importance of early care must not be underestimated. In one study of women with postnatal depression, it was possible to predict at three months of age which children would have the greatest difficulties in school a decade later. The study showed that children whose mothers had postnatal depression were 12 times more likely to have a statement of special

needs for emotional, behavioural or learning problems. This was the case even when taking into account other factors, such as social class, the mother's IQ, family structure, or chronic maternal mental health problems.²³ Teenage mothers have three times the rate of postnatal depression of older mothers and a higher risk of poor mental health for three years after the birth.⁵⁰

Although full psychiatric diagnoses are not usually made during the early years, 7% of three year olds show moderate to severe behavioural problems, and a further 15% show milder difficulties.³⁹ Many early development and habit problems (such as delays in toilet training, or 'comfort' habits such as rocking and thumb-sucking) will pass, but a substantial proportion of the most severely troubled pre-school children will go on to develop psychiatric disorders later in childhood. Longer follow-ups have shown some continuities between pre-school behaviour problems and both psychiatric disorders and criminality in early adult life.³⁹

It makes sense to tackle the causes of later mental health problems as early as possible, and infant mental health is a rapidly growing research area. However, at present the role of charities is limited. Supporting charities working with parents and families can provide a good way for donors to intervene at an early stage.

Adolescence is a time of rapid development and a peak time for the onset of serious mental illness, particularly mood disorders such as depression, and psychotic disorders such as schizophrenia. It is also a peak time for eating disorders and self-harm. During this period, young people undergo enormous psychological, emotional and social change as they make the transition from supported child to independent adult.

Recent research into brain development illustrates the difficulties of adolescence very clearly: 'The brain structures mediating emotional experience change rapidly at the onset of puberty, generating powerful emotional urges for sexual behaviour, independence, and the formation of social bonds. However, the maturation of the frontal brain structures that underpin cognitive control lag behind by several years. This leaves the adolescent with powerful emotional responses to social stimuli that he or she cannot easily regulate, contextualise, create plans about or inhibit.'⁵¹ According to one expert, this is like 'starting an engine without yet having a skilled driver behind the wheel'.⁵¹ While this can be a time of great opportunity, for those who are exposed to many risks it can be a potentially devastating phase of development.⁵¹

“The onset of adolescence is like starting an engine without yet having a skilled driver behind the wheel.”

Young people need considerable support during the teenage years and in the transition to adulthood. However, this is also the time when statutory mental health services are arguably at their weakest. Providing ongoing, age-appropriate care, especially for 16–25 year olds, therefore often falls to charities.

Who is affected?

Mental health problems can affect anyone, but some children and young people are more vulnerable than others. Children with a mental health problem are more likely to be boys, living in a lower income household, in social sector housing and with a lone parent.^{6, 52} There is also a particularly high prevalence of problems among certain groups, including children in care, children with learning disabilities and children with chronic or persistent physical ill-health.

It is important to emphasise that these are *associations* and not necessarily direct causes. The majority of children and young people in these circumstances grow and develop without difficulties.⁵³ Features that are associated with mental health problems, such as lower educational attainment, absences from school, weaker friendship networks, poorer physical health and antisocial or criminal behaviour, may in fact be more of a product than a cause.⁵³

Why some children in difficult circumstances cope and ‘succeed’ when others do not is difficult to establish. One way of understanding this is in terms of ‘resilience’. Resilience is an aspect of good mental health that can be defined as the ability to cope with difficult or distressing events. Resilience in children can be encouraged by reducing exposure to risks (eg, deprivation, poor maternal health, divorce and parental conflict) and developing protective characteristics (self-esteem, educational achievement and good relationships with friends and adults). Resilience is discussed in more detail in Chapter 2.

Vulnerable groups

Certain groups of people are more at risk of experiencing mental health problems. NPC has researched many of the issues that are associated with poor mental health in these groups (as shown in Table 1) and plans to cover substance abuse, children in care and youth offending as part of future research.

Table 3 provides a rough picture of the extent to which different groups are vulnerable to mental health problems. It is based on a range of sources so numbers are not strictly comparable. Some studies are more recent than others, and use different geographical coverage, age ranges and methods. Some children and young people will belong to more than one group.

Table 3: Mental health disorders in vulnerable groups

Vulnerable groups ³⁹	Number in UK	Proportion with mental health disorder
Total child population 5–15	8.1 million ⁵⁴	10% ⁶
Children in care (England)	61,000 ²⁷	45% ⁵⁵
Generalised learning disability (GenLD)	194,000	33–50% ³⁴
Victims of child abuse	80,000 annually ⁵⁶	Not known
Homeless young people (16–21)	32,000 ⁵⁷	60% ³⁹
Young offenders (15–20)	12,000 ⁵⁸	40–95% ^{27, 59}
Children with a parent who has a mental health problem	2 million ¹⁶	20% ⁶⁰
Refugee children	60,000 ⁶¹	40% ⁶¹
Children who have witnessed domestic violence	240,000 ⁶⁰	25% ⁶⁰

Children in care are looked after by the local authority, and are placed in foster families or residential care homes, away from their natural parents. It is estimated that 45% of children in care have mental health problems. However, one study found that the prevalence rate of disorders in adolescents in the Oxfordshire care system was 67%, with 96% of adolescents in residential units and 57% of those in foster care having mental health disorders.⁶²

Victims of child abuse suffer pain, fear and loneliness. This can result in anxiety and behavioural problems and may also lead to problems with learning and communication. There are strong links between abuse in childhood and mental health problems. Half of people accessing mental health services report abuse as children.⁵⁶

Children exposed to domestic violence experience trauma and insecurity. A study by the National Society for the Prevention of Cruelty to Children (NSPCC) estimated that one child in twenty witnesses frequent physical violence between parents.⁶³ Around one child in four who has witnessed domestic violence will experience serious social and behavioural problems.⁶⁰

Children with learning disabilities are at high risk of having mental health problems. Generalised learning disability (‘GenLD’) affects around 2% of the population. It is not itself a psychiatric disorder, but roughly a third of children with mild GenLD and half of those with severe GenLD will have a psychiatric diagnosis.³⁴

Young offenders are often affected by mental health problems before, during and after their imprisonment or community sentence. These problems may be both a cause and an effect

Half of people accessing mental health services report abuse as children.

Children of parents with mental health problems are twice as likely to experience a childhood psychiatric disorder.

of their involvement in the youth justice system. Actual prevalence estimates vary considerably (from 40–95%), but the scale of vulnerability is demonstrated by the high rates of suicide or attempted suicide among young offenders.²

Children of parents with mental health problems are twice as likely to experience a childhood psychiatric disorder.⁶⁰ One estimate suggests that as many as two million children are living with a parent who has a mental health problem,¹⁶ though the real figure may be lower given that a recent government paper shows that there are around 450,000 parents with a mental health problem.⁶⁰

Black and minority ethnic (BME) groups are over-represented in mental health services and there is a lack of care that is sensitive to their cultural and religious backgrounds.^{28, 64} Black Africans and Caribbeans make up just 2.7% of the youth population in England, but they account for 13% of the young people detained on adult wards.^{14*}

Young refugees and asylum seekers are often traumatised by the problems that made them flee, which may include war, torture, violence and loss. They are also disoriented and confused by their experiences when they arrive in the UK. Up to 40% of refugee children have mental health disorders such as post-traumatic stress disorder and depression.⁶¹ Others may suffer from anxiety and emotional problems related to their isolation.

Children with chronic health problems, whether physical or neurological, experience a much higher incidence of mental health problems than the general population. A recent survey shows that young people with a physical illness are twice as likely to have developed an emotional disorder than those with no physical illness.²¹

How many are affected?

Prevalence

At any one point in time, around one in ten children has a diagnosable mental health problem.⁶ The prevalence of different mental health disorders is shown above in Table 2. According to these statistics, it is estimated that in a secondary school of 1,000 pupils, approximately 112 children will have a mental health disorder, of which:

- 46 will have an anxiety disorder;
- 18 will be seriously depressed;

- 62 will have a conduct disorder; and
- 14 will have a hyperkinetic disorder or severe ADHD.^{65†}

Unfortunately, the data that specifically looks at young people's mental health in the 16–24 age range is limited. However, studies show that the proportion of young people with mental health problems increases from age 15 to 18, and it has been suggested that the late teens and early twenties are periods of especially high risk for mental health problems—‘possibly the highest at any stage in the life course’.^{39, 66} One report suggests that as many as one in five young people aged 16–24 has a recognised mental disorder.⁵¹

Geographical distribution in the UK

Geographical differences in prevalence tend to occur *within* rather than *between* regions, and there is strong evidence associating mental health problems with almost every form of persistent disadvantage in society. One study showed that rates of disorder are twice as high in inner city London as compared with the Isle of Wight, suggesting that this could be explained largely in relation to the greater frequency of family disadvantage and discord in inner London.⁴⁹ In some deprived urban areas, the incidence of mental ill health has been reported to be as high as 40%, compared to 10% in ‘average’ neighbourhoods.⁶⁷

Trends

Mental distress, conduct disorders and emotional problems among adolescents have all increased since the 1970s, and have doubled since the early 1990s.⁶⁷ But recently, rates of disorder have remained stable. There was little change between prevalence rates in 1999 and 2004.⁶ Reported rates of deliberate self-harm increased dramatically between the early 1950s and the late 1980s, and although they have fallen steadily since then, they remain high.³⁴

Some people believe that higher rates of reported mental health problems are due to an increasing trend towards ‘medicalising’ bad behaviour, or treating temporary problems as ‘illness’. However, studies seem to agree that there is a real, rather than perceived, increase in prevalence.⁴⁹ Young people diagnosed with mental health problems are still experiencing poor outcomes later in adulthood, suggesting that trends are not the result of an increasing tendency to pathologise young people's problems, but are the result of real changes in mental health.²⁴

* NPC could not find an equivalent figure for paediatric and adolescent wards.

† These figures do not add up because some children will have more than one disorder.

Although suicide rates in the UK have declined steadily since 1993, it is still the case that one young person tries to commit suicide every 30 minutes.² Young men are at particular risk. In England, there has been a fall in the rate of suicide among young men, but the death rate from suicide in this group is still high in comparison with the general population.⁶⁸ There is also evidence that while the number of completed suicides has fallen, attempted suicide by young men has tripled since 1985.²

These issues were brought to wider public attention by the high number of suicides in Bridgend in south Wales in 2007 and 2008. Unofficial figures suggest that 20 young people under the age of 27 committed suicide in Bridgend in the space of a year and a half. The majority were young men and some knew each other. Fears that a possible 'cluster' of copycat suicides had been encouraged by internet sites generated extensive media coverage. Many people feel that media reporting has been irresponsible, misrepresenting the situation in Bridgend and glamourising suicide.^{69, 70}

How does the UK compare with other countries?

On most measures, the UK does not compare well with other countries. There has been a growth in mental health problems and poor emotional well-being in the UK that is not matched elsewhere.⁷¹ In particular, the sharp increase in conduct and emotional problems in the UK is not discernable in other countries with similar profiles.

In February 2007, UNICEF published a report that placed the UK bottom of a list of 21 developed countries for children's well-being. Of the six measures of well-being included in the research, the UK was ranked bottom on three: young people's behaviour and risks; subjective well-being; and relationships.⁷² According to another UNICEF report, Britain also has the second highest teenage birth rate in the developed world.⁷³ Being a mother so early in life has many social, behavioural and health consequences, including a greater likelihood of depression compared to other teenagers.⁵⁰

A World Health Organisation (WHO) report looking at 35 countries and 162,000 young people aged 11, 13 and 15 found that teenagers in the UK exhibited 'worryingly high' levels of risky behaviour.⁷⁴



Photograph supplied by the Medical Foundation for the Care of Victims of Torture

What are the costs?

Effects on individuals

Mental health problems make children miserable and vulnerable, sometimes to the point that they wish to harm themselves. They also affect other aspects of the child's personal, family and community life, educational achievement, physical health and relationships. Problems may persist or recur throughout childhood, and many continue into adult life.

Children with mental health disorders tend to have poorer general health than other children and are much more likely than other children to have time off school, including unauthorised absences. Their ability to empathise is often poorer and, in many cases, they have fewer friends and are not as close to their families.⁴¹ They are also more likely to need special educational help and get into trouble with the criminal justice system.³⁹

Won't they grow out of it?

Sadly, for many children and young people experiencing mental health problems, it is not simply a case of 'growing out of it'. As one study argues, *'for many young people, mental health problems in childhood mark the early stages of difficulties that continue well into adult life.'*⁷³⁹ Three years after presenting with a mental health disorder, two-thirds of children and young people are still affected.⁷⁵ Three quarters of adults with mental disorders had one in childhood.^{75, 76} Research also suggests that disorders with onset in childhood have more serious adult consequences than later onset conditions.⁷⁶

UNICEF's 2007 report placed the UK bottom of a list of 21 developed countries for children's well-being.

75% of adults with mental health disorders also had one in childhood.

As children and young people with mental health problems grow up, they are more likely than others to experience difficulties with relationships, unstable employment, loneliness, poverty, homelessness, substance abuse, and criminal behaviour.²⁴ Recent analysis by the Institute for Public Policy Research (ippr) suggests that the emotional well-being of a young person age 16 is a strong predictor of his or her mental health and life chances age 30.⁷⁷

Effects on families

The needs of children can place considerable burdens on families and carers. Most parents are distressed by their child's problems. According to one study, over half felt that their child's disorder had caused them to be depressed,³⁹ and almost a third felt embarrassed and stigmatised by their child's problems.³⁹ In all areas, conduct and hyperkinetic disorders have a greater impact on family life than emotional disorders.

Effects on communities

There are strong associations between antisocial behaviour and mental health problems. A considerable body of research shows that antisocial behaviour during childhood (vandalism, substance abuse, carrying a weapon) is one of the strongest predictors of later adult antisocial behaviour, especially serious, habitual and violent crime.⁷⁸

Box 6: The cost of conduct disorder

NPC estimates that conduct disorder in children and young people costs £1.5bn up to the age of 25, and much more if projected forward into their futures. These costs include involvement in the criminal justice system, education, health and foster care costs, and lost earnings. Yet conduct disorder is treatable. A study into the efficacy of parenting programmes showed that on average, two-thirds of children under ten years whose parents take part show improvement, with effects detectable for up to four years.⁵ But at the same time, research in 2006 suggested that three quarters of children with a diagnosable problem of any kind were not receiving sustained, appropriate treatment over three years. The same source indicated that less than half of children with a diagnosable problem were getting support from any professional.¹¹

These startling statistics and observations led NPC to estimate the potential to save costs by investing in treatment. We estimate that it would cost an extra £30m to treat all 28,700 children in England who have conduct disorder. Not all treatments would be successful, and some treatments would be only partially successful, but we still estimate that a comprehensive treatment programme could save society between £244m and £376m per annum. This represents a return on investment of between 810% and 1,250%. (Further details are included in Appendix 1 on NPC's website.)

These are purely economic calculations and do not take into consideration the enormous human and emotional benefits of overcoming conduct disorder. Combining the economic costs and the human benefits makes a compelling case for action. Conduct disorder is just one example of many conditions affecting children and young people. Other conditions may cost society and individuals just as much.

However, it is important to emphasise that it is not only children and young people with mental health problems who are involved in antisocial behaviour.

As well as the obvious problems that antisocial behaviour causes, communities also lose out on the individual's potential to make a positive contribution. It is harder for a person on a trajectory of poor mental health and crime to make a contribution to their own families and communities. Therefore, the more people are affected by mental ill-health, the more 'social capital' is lost by communities.

Effects on society

A large number of young people with mental health problems will grow into adults who experience not only ongoing mental health problems, but also a range of other poor outcomes.²⁴

Research has shown that by the age of 28, people with continuing high levels of antisocial behaviour have cost society up to ten times more than those with no problems.²⁴ NPC's conservative estimate suggests that the total cost of a child with conduct disorder comes to £52,169 by the time the child is 25. Most of this is the cost of crime. The total cost that all eight year olds in England with conduct disorder are likely to accrue by the time they are 25 is estimated to be approximately £1.5bn (see Box 6). Further details are included in Appendix 1 on NPC's website.

When you consider the link between childhood and adult mental health problems, the lifetime costs are enormous. A report commissioned by the King's Fund estimated that the cost of services to people with mental health problems in England was around £7.65bn in 2007.⁷⁹ Previously, the Sainsbury Centre for Mental Health had estimated the overall cost of mental ill health to society in England at £77bn per year. This includes the costs of care and lost output in the economy, as well as costs associated with reduced quality of life and loss of life.⁸⁰

The social and economic impact is significant:

- Between 13 and 91 million working days are lost every year due to stress, depression, and anxiety.^{81, 82}
- Mental health problems account for 40% of people on Incapacity Benefit.⁸³
- Treating mental health problems is estimated to take up about a third of GPs' time.⁸³

Tackling the problem

Since it is well-established that the roots of most adult mental health problems lie in childhood, what can be done in early life to prevent these individual, social and economic costs? As we have seen, more than one in ten children and young people experiences poor mental health. But there are positive responses to these problems that can help people to overcome health problems.

Logically, the solutions lie in:

- supporting children who are vulnerable as a result of genetics, temperament or circumstance;
- promoting the resilience and psychological well-being of children through good maternal health, healthy infancies and childhoods, and sound parenting;
- tackling problems within families—if necessary targeting help towards ‘at risk’ groups;
- improving the school environment, as well as using schools to reach and support vulnerable children;
- developing healthy communities with opportunities for play, exercise and

constructive activities, rather than antisocial behaviour and substance abuse;

- improving wider society so that it is more welcoming towards children rather than vilifying them or setting them up for failure against unrealistic role models; and
- providing support and treatment quickly and effectively when mental health problems emerge in children and young people, so as to minimise distress and set them on positive paths to recovery.

But first we need to determine whether any of these solutions work, and examine what action government is taking. Then we can identify how charities and donors can best contribute to existing efforts.

NPC estimates that conduct disorder in children and young people costs £1.5bn up to the age of 25.



Photograph supplied by Kristian Buus



Photograph supplied by Family Action

What works in improving mental health?

Mental health problems carry huge human, social and economic costs. What can be done to improve the lives of children and young people affected, and to support the well-being of children more broadly?

Over the last decade good headway has been made in our understanding of what works in improving children and young people's mental health. Knowledge about the most effective forms of treatment continues to grow, but there are still significant gaps in the evidence. Donors and charities can help to fill these gaps by contributing to research and evaluation.

Programmes to prevent the development of mental health problems and promote emotional well-being are now on the government's agenda as well. Many of these are promising—for example, programmes to improve parenting skills and increase access to talking therapies. However, most are still in the early stages of development and, without careful evaluation, there is a danger that policy may run ahead of the evidence.

This chapter will outline what is known about how to promote good mental health, and prevent and treat mental health problems. It will also highlight where there are gaps in the evidence, and where donors and charities can help by contributing to research into what works.

How can we improve mental health?

Mental health problems are seldom straightforward. They are the product of a complex mix of factors and rarely fit neatly into diagnostic categories with simple solutions. Children are likely to show different symptoms depending on the situation, and one in five children with a mental health problem is diagnosed with more than one disorder.⁶

When thinking about how to prevent and treat mental health problems, we need to be aware of this complexity and avoid a 'one size fits all' approach. The skill of the doctor or therapist lies in their ability to assess the individual child or young person's needs and preferences, and then to decide on the course of treatment that best suits their circumstances.⁵

The complexity of diagnosis is well illustrated by the case of a ten-year-old boy, Simon, who has conduct and hyperactivity problems. He regularly starts fights, has run away from home, and is disruptive in class. He is easily distracted and is aggressive with peers and teachers. As a result, Simon is referred to a child mental health specialist. By carrying out a full assessment, the specialist finds a whole range of associated problems. These include:*

- an inherited predisposition to hyperactivity;
- dietary intolerance to citrus fruits and additives;
- reading difficulties;
- a tendency to mistakenly view other people as hostile;
- inadequate parental supervision;
- a family environment where he has to act forcefully to get attention; and
- involvement in a deviant peer group.

Although tackling any one of these issues might help, addressing several of them at once is likely to be more effective. This might involve:

- reducing his hyperactivity through medication and diet;
- improving his 'internal world', eg, through cognitive behavioural therapy (CBT) or another psychological therapy;
- improving his family's understanding of his condition, for example through explanatory leaflets;

Mental health problems rarely fit neatly into diagnostic categories with simple solutions.

* The following is adapted from an example in a well-known textbook on child psychiatry.³⁴

It is important that mental health specialists work in partnership with other professionals, such as schools and social services.

- targeting specific symptoms through parent-training programmes or behaviour therapy;
- improving family relationships through family therapy;
- providing extra support at school, eg, help with reading or initiatives to combat bullying; and
- improving the behaviour of his peer group, eg, through group therapy or social skills training.

This approach to treatment might also include looking at the family circumstances and issues like housing or social isolation.³⁴

This example highlights the range of risks to which Simon is exposed, and the variety of techniques that might be used to help him. It also demonstrates how important it is that mental health specialists work in partnership with other professionals, such as schools and social services, in order to address the range of different problems faced by a troubled child or young person.

Could something be done sooner?

Simon's case raises a number of questions about the best way of tackling mental health problems: not least, could the problems have been tackled earlier? Could his parents have been given help to improve the family environment before problems escalated? Could he have received extra support for his reading? Could aspects of the whole school environment have been improved, so that pupils had more exercise, healthier food and more supportive peer groups?

Approaches to improving mental health need to work at a number of levels:

1. Promoting good mental health and resilience among the general population of children and young people, to help them enjoy life and cope with stressful situations.
2. Providing targeted support for children and young people who are exposed to risks, in order to prevent mental health problems from developing.
3. Identifying mental health disorders at an early stage and providing timely and appropriate treatment to manage or minimise their symptoms.
4. Providing treatment and care for young people in crisis who may not have been picked up at an earlier stage.
5. Providing ongoing support and care during recovery for those who experience problems. This includes helping children and young people to manage symptoms and reintegrate into communities, reducing the chances of relapse.

Historically, the structure of mental health services and a lack of resources has meant that Child and Adolescent Mental Health Services (CAMHS) have had to focus on treating children and young people with serious conditions who are in or near crisis.

Over the last decade, the governments in England, Scotland and Wales have started to place more emphasis on promotion, prevention and early intervention. For example, they have introduced policies to promote positive mental health and support vulnerable children and young people, such as the *Social and Emotional Aspects of Learning (SEAL)* and *Targeted Mental Health in Schools* programmes in England.

This chapter looks at the different approaches—promotion, prevention, treatment and recovery—and discusses what we know works, and where further research is needed. The discussion will be quite technical, so some readers may prefer to move straight onto Chapters 3 and 4, which cover what government and charities are doing in practice. However, this discussion is very much at the heart of the debate concerning children and young people's mental health and how it should be improved.

Promoting good mental health and preventing problems

NPC has found that there is a growing body of research about how to promote the emotional well-being of children and young people, and prevent the development of mental health problems. These two approaches are difficult to separate. Features associated with emotional well-being—such as self-esteem, confidence, good social and communication skills—are also linked to resilience, which is the ability to withstand stress and trauma without developing serious mental health problems.^{2, 84}

Box 7 discusses some of the features associated with resilience. We can think about developing resilience in two main ways.

First, we can reduce the external risks to a child's mental health and therefore protect them from harm. Treating postnatal depression in new mothers might be an example of this, as postnatal depression has been proven to have a negative impact on a child's development. Tackling bullying in schools might be another.

However, as the eminent child psychiatrist Professor Sir Michael Rutter has noted: '*The promotion of resilience does not lie in an avoidance of stress, but rather in encountering stress at a time and in a way that allows self-confidence and social competence to increase through mastery and appropriate responsibility.*'⁸⁴

This leads onto our second point: we can nurture a child's internal capacity for coping with stress. Research has demonstrated that building children's self-belief (including their sense of autonomy, optimism and purpose), and helping them to acquire social, communication and problem-solving skills, contributes to their resilience. These attributes may be developed through good parenting, and it is important that a child or young person has at least one secure and stable relationship in his or her life. They may also be developed through participation in school or extracurricular activities, which give children a chance to experience success or achievement, take on responsibility, overcome challenges and make new friends. Conversely, research has shown that a sense of helplessness and worthlessness can lead people to behave as if they are 'at the mercy of fate', rather than taking positive steps to improve their circumstances.⁸⁴

It is important to think of mental health promotion in a more positive light than simply building resilience to cope with adversity. Emotional well-being confers benefits as well. Research suggests that it can enhance motivation, educational achievement, and communication and social skills. Emotions such as feeling safe and valued improve children's capacity to learn and support the development of rational thought. Sadness or anger can block learning and impair a child's ability to make decisions, prioritise and plan.⁸⁵

Promising approaches

NPC has come across examples of promising programmes that address the risks to mental health that children and young people encounter at home, at school and in the community, and promote emotional well-being.

Some programmes take a universal approach, working with an entire school or community. Others are more targeted and concentrate on individuals who are known to be at higher risk of developing mental health problems, due to genetic disposition or social and economic circumstances. High-risk groups include: children whose parents have mental health problems; abused children; and young refugees and asylum seekers. NPC has focused on ways of helping many of these groups in separate reports.

Both approaches are valuable. Universal approaches may raise awareness of mental health issues among children, parents, GPs, teachers and other adults. This should encourage earlier identification and intervention, which is very important. Mental health problems are best tackled in their initial stages, when symptoms are still mild, since negative behaviour patterns tend to become more

Box 7: What builds resilience?

Research by Barnardo's has identified features associated with resilience. These include:

Before birth

- Good maternal health, including good nutrition, avoidance of smoking, moderate alcohol consumption.
- Social support for mothers, good antenatal care and absence of domestic violence.

Infancy

- Adequate parental income, good quality housing, safe areas to play and provision of learning materials.
- Support for mothers from male partners, family and social networks, and parent education.
- Breastfeeding to three months.

Pre-school

- Good quality pre-school day care and availability of alternative carers.
- Preparatory work with parents on home-school links, and links with other parents, community and faith groups.
- Food supplements.
- Pairing with resilient peers.

Middle childhood (5–13 year olds)

- Positive school experiences relating to academic work, sport or friendship, and good relationships with teachers; participation in breakfast and after-school clubs.
- Opportunities to develop skills, independence, and self-esteem.
- Structured routines at home and school, with the fair use of praise and sanctions.
- Good home-school links for vulnerable children and their families, which help promote parental confidence and involvement.
- Support in stressful situations, both minor and acute, and opportunities to develop attachments to reliable adults and to play a positive role in the family.

Adolescence and early adulthood (13–19 year olds)

- Positive school experiences and participation in extracurricular activities.
- Opportunities to 'make a difference' by helping others or through part-time work, and to be exposed to challenging situations.
- Strong social support networks, at least one unconditionally supportive parent or carer and a committed mentor from outside the family.
- The capacity to learn from adversity, recognising the beneficial as well as the damaging effects.

Source: Tony Newman (2004) *What works in building resilience?* Barnardo's.¹³

entrenched as people get older.⁸⁵ Universal approaches are also beneficial as they do not stigmatise or isolate people who are suffering from problems. Targeted approaches provide more tailored and intensive support for specific issues. Ideally, a combination of the two is desirable.

Parenting has a huge impact on children's mental health, particularly during the first two years of life.

At home

The family and home environment has a critical influence on children and young people's development. Parenting has a huge impact, particularly during the first two years of life, when brain development is very rapid.⁸⁶

Risks may be mitigated by programmes that:

- **Improve the health and diet of pregnant women.** Research has shown that children are affected by the diet, alcohol consumption and mental health of their mothers while they are in the womb.⁸⁶ Public health campaigns and prenatal classes may help by raising awareness and recommending good practice for supporting maternal health.
- **Improve parenting skills** (see Box 8). Group parenting classes have been shown to reduce children's behavioural problems. Home health visits, particularly for first-time mothers, beginning during pregnancy and continuing for two years, have also been associated with improvements in parenting skills. They also support the physical and mental health of children, the management of postnatal depression and the quality of the home environment.⁵²
- **Strengthen child–carer relationships.** Psychotherapy, play therapy and school–parent initiatives can help build attachment between parent and child and improve communication and the expression of emotions.^{87, 88}
- **Manage parental mental health problems.** This is particularly relevant for postnatal depression. Home health visits and parenting-skills training have been associated with improved maternal health, as discussed above.⁵²

Parenting and support for children in their early years has been a focus of recent government policies, particularly through the development of *Sure Start* Children's Centres. Such initiatives aim to offer support to vulnerable groups, including deprived families, single-parent families, and children affected by traumatic events such as abuse, bereavement or divorce.

At school

From the age of four or five until their late adolescence, children spend a significant amount of their time at school. It is therefore important that school staff are well-equipped to promote good mental health, identify problems at an early stage, provide appropriate support and, where necessary, refer on to specialist mental health services.

Approaches to improving mental health in schools tend to take two forms:

- **Whole-school or open-access programmes** for promoting good mental health across the school population. For example, the government's *Social and Emotional Aspects of Learning (SEAL)* programme; class 'circle time' for discussing emotions and issues; extracurricular activities that develop self-esteem and confidence; training for teachers around managing pupils' mental health; and information campaigns about specific problems (eg, eating disorders).
- **Targeted support** for vulnerable children and young people, including those who are withdrawn, disruptive or have suffered from stressful events such as bereavement, divorce or bullying. Support may consist of one-to-one counselling; drama, music, art or play therapies; mentoring and befriending schemes; or extracurricular activities tailored to specific groups, such as under-confident children.

School-based programmes will be discussed further in Chapters 3 and 4.

The National Institute for Health and Clinical Excellence (NICE) recommends a combination of universal and targeted approaches for promoting social and emotional well-being in primary schools. Its guidelines identify the types of support that schools should provide, and how they might be implemented.^{89*}

Although some projects or charities have demonstrated their results through rigorous evaluations, the evidence for school-based programmes is generally patchy, and most of the evaluations come from the United States.^{91†} This is particularly the case for whole-school approaches, whose success is often dependent on the ethos of the school and support of the senior management team.⁵²

In the community

As children and adolescents grow up, they spend more time outside their home or school, with their friends. Support at home and school is not enough; approaches to improving mental health also need to work with young people on the street, in youth clubs and in other community settings. This is particularly important when you consider that the disruptive behaviour that is associated with truancy or exclusion from school and youth offending may be related to mental health problems.

* Equivalent guidance for secondary schools is under development, due for publication in 2009.⁹⁰

† Of 427 studies on social and emotional learning programmes reviewed by the Oxford Institute of Health (most of which came from the US) only 14 were deemed sufficiently rigorous to include in its systematic review.⁸⁵

Box 8: Supporting parents

We know that parenting has a significant impact upon children's psychological well-being and that children from dysfunctional families risk developing mental health problems. Working with families to improve parenting skills therefore makes sense.

This logic is borne out by mounting evidence of success from different parenting interventions developed in the US, Australia and the UK. The potential to transfer these interventions between countries seems promising, but further evidence is needed. Two systematic reviews of evidence make a strong case for parenting or family-related programmes: one on parenting support was completed in 2004 for the then Department for Education and Skills; the other reviewed six interventions for children at risk of developing antisocial personality disorder, and was completed in 2007 for the Department of Health and the Prime Minister's Strategy Unit.⁸ The main conclusions are as follows:

- The evidence for reducing conduct disorders and antisocial behaviour, including substance abuse and offending, from six sampled interventions was persuasive.^{*8}
- There is more evidence available for parenting programmes that tackle conduct disorders and antisocial behaviour than there is for parenting programmes tackling depression and anxiety in children. This is because more resources have been available for studies tackling disorders that are antisocial and disruptive, rather than any evidence that parenting programmes do not benefit anxious or depressed children. So there is an evidence gap here where research would be useful, particularly given the potentially high long-term costs of depression and anxiety.
- Both group and individual parenting programmes can be successful. Some parents do well mixing with their peers, while others need a more private intervention.
- Programmes that work for older children, and programmes preventing substance abuse, are more effective if they: tackle the family's multiple problems; are flexible and tailored; and use a strong theory of change.
- Work with older children who have established behaviour problems can result in the children's behaviour becoming worse if the children are put into groups. This approach is therefore risky.
- High-quality staff are essential for the delivery of the programmes.
- Early years support programmes seem promising, but more evidence is needed.^{8, 15}

The government in England's *Sure Start* initiative aims to help young children and their parents by developing Children's Centres in disadvantaged areas that bring together childcare, early education and family support. The most recent evaluation of these *Sure Start Local Programmes* (SSLPs) also offers some promising findings about the benefit of outside help to families. The evaluation states that, when compared to children in areas where there was no SSLP, '*SSLP children showed better social development, exhibiting more positive social behaviour and greater independence/self-regulation than their non-SSLP counterparts. Parenting showed benefits ... with families in SSLP areas showing less negative parenting while providing their children with a better home environment. The beneficial parenting effects appeared to be responsible for the higher level of positive social behaviour in children in SSLP areas.*'²² However, the detailed data does not tell us what exactly is working for which groups of people, so it is difficult to extrapolate lessons for expansion from this study.

Specific issues—such as postnatal depression (PND), which affects about one in ten new mothers—can affect parent-child bonding and child development in infancy.¹ A study showed that children whose mothers have PND are almost 12 times more likely to have a statement of special needs for emotional, behavioural, or learning problems.²³ Therefore, it would make sense to tackle PND to reduce these effects. There are no studies, however, to show that treatment for PND benefits the children, as research into PND treatment focuses on the benefits to the mother. This example serves to show that when tackling the mental health of children and young people, there may be some unusual routes for charities and funders to take in prevention and early intervention.²³

* The interventions sampled were: The Incredible Years; Triple P (Positive Parenting Programme); the Nurse-Family Partnership home-visiting programme; multisystemic therapy; multidimensional treatment foster care; and functional family therapy.

Parenting classes have been shown to reduce children's behavioural problems.

Children and young people gain confidence and a sense of control from participating in positive, structured extracurricular activities.

Targeting mental health initiatives at young people in the community is more difficult—there is not the same compulsion to participate as there may be at school or in the home. Community-based programmes therefore need to be good at engaging young people. This may involve using activities that young people enjoy, such as sport or art, as a vehicle for providing broader emotional and social support.

Positive group activities can improve young people's mental health and resilience. They are associated with low levels of depression and anxiety and high levels of motivation and self-esteem among teenagers. Children and young people gain confidence and a sense of control from participating in extracurricular group activities that are structured, have a clear hierarchy, regular meetings and well-defined aims (eg, working towards a final performance or tournament).⁷⁷

Yet these activities do not tend to be targeted at the young people who need support the most. Children in disadvantaged areas are much less likely to have access to such activities than children from more affluent backgrounds.⁷⁷

Offering access to more specialist mental health support through community drop-in centres can also help to prevent or manage the development of mental health problems. Organisations known as Youth Information, Advice, Counselling and Support Services (or YIACS), the majority of which are charities, provide this sort of support, for example by offering free and confidential counselling and therapy sessions to young people who walk in off the street. The importance of simply giving young people the opportunity to discuss their problems should not be underestimated, as Box 9 notes.

School and community-based out of school hours activities for young people and the role of YIACS will be discussed in Chapter 4. Readers may also refer to NPC's report *After the bell*, which focuses on out of school activities.

Box 9: Who's listening?

Young people need to know that they have someone they can talk to when they are finding it difficult to cope. One interviewee told the *National Inquiry into Self-Harm*: 'What they [school staff] fail to consider is that maybe a young person simply needs someone to talk to, not specifically about self-harm, but about the problems and issues they are facing in their daily lives which make them turn to self-harm as a way of simply surviving—and I believe that this listening is one of the most fundamental values of good youth work!'³

This is not to say that a listening ear is enough on its own—in many cases, it is important that a young person is referred onto a mental health specialist. But a trusted confidante can help them work through issues at an early stage and encourage them to seek specialist support for a problem that they might feel ashamed about.

The need for partnership

Promotion and prevention falls into the remit of the health profession on the one hand, and the education and social care professions on the other. This can lead to a lack of clarity over responsibilities. It can also lead to a lack of consistency, as the different professions have different approaches to structuring and evaluating programmes. For example, randomised controlled trials (RCTs) are the gold standard for evaluating healthcare programmes, but tend to be less widely used in education and social care.

NPC believes that greater partnership and communication across professions is vital throughout the mental health sector, but may be particularly important when it comes to the development of effective approaches to promotion and prevention.

Messages for charities and donors

Research into promotion and prevention has already identified many of the risks associated with mental health problems, and many of the features associated with emotional well-being and resilience. However, there is a need for further investigation of the most effective ways of translating the theory into practice. The majority of what we know is based on evaluations of projects in the US but, even there, educational policy on positive mental health (often referred to as 'emotional intelligence') has run ahead of knowledge about what works.⁸⁵

Charities can help by carrying out research and rigorously evaluating new programmes. In particular, the evidence for what works needs to be improved in terms of:

- building resilience in families, schools and communities;⁹²
- promoting good mental health and emotional well-being; and
- measuring emotional well-being and its benefits.

Donors can help by supporting academic research and the evaluation of experimental approaches conducted by charities, as mentioned above. Funding options are discussed in detail in Chapter 6.

Treating mental health problems

What works

Once mental health problems have been identified, children and young people may be referred to specialist mental health services. While promotion and prevention is often in the realm of education and social care, the treatment of diagnosed disorders is strongly influenced by medical professionals. But it is by no means an exact science—treating a mental health disorder is not like fixing a broken bone. As discussed in Chapter 1 and at the start of this chapter, the diagnosis and treatment of mental health disorders is complex. It involves a range of inter-related approaches and professionals, and depends significantly on the skills and empathy of individuals working with children and young people. It cannot be based on rigid criteria of ‘what’s wrong’ and ‘what works’.

Table 4 summarises the different treatments recommended for specific disorders, based on guidelines from the National Institute for Health and Clinical Excellence (NICE), and key texts on child psychiatry. It gives an overview of the suggested approaches to treating different disorders. However, NPC has not undertaken a systematic review and the table is not designed as a comprehensive guide to good practice. In particular, it does not cover developmental disorders, such as autism or learning disabilities, which have been discussed in previous NPC reports.^{93, 94*} A glossary of

specialist terminology can be found at the back of this report.

Readers should be aware that even the most respected experts on ‘what works’ have strong reservations about the extent of what we know. It is also important to emphasise that these guidelines have a medical bias that does not reflect the full range of professionals and approaches involved in treating mental health problems, many of whom would not describe what they do as ‘treatment’. There is a great deal of work done by professionals of all kinds—psychotherapists; play, art, and music therapists; mental health and youth workers—that is not included here. The relative lack of research into other therapies and approaches does not necessarily mean that they are not effective.³⁰

Treatment options may reflect a bias in terms of which research is funded, which approaches are most readily measurable, and which interventions show more immediate results. Certain approaches may be inherently difficult to measure or have longer-term outcomes that go unrecognised. As with promotion and prevention, there can also be a gap between theory and practice: RCTs are often not conducted in the sort of settings where people would normally receive treatment. So, it cannot be assumed that because an RCT has shown that a particular treatment works, it will always be effective in routine practice. Careful monitoring and evaluation of how treatments are delivered is therefore vital.

The treatment of mental health disorders is by no means an exact science.



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* For more detailed guidance, readers should go to the NICE website (www.nice.org.uk) or refer to the report, *Drawing on the Evidence: Advice for mental health professionals working with children and adolescents*.^{5, 95}

Table 4: Recommended treatments for children and young people's mental health disorders

Mental health disorder / symptom	Recommended treatments
Depression	<ul style="list-style-type: none"> For mild depression: 'watchful waiting' for up to four weeks. Non-directive therapy, group cognitive behavioural therapy (CBT) or guided self-help may be beneficial if depression does not improve after that.^{49, 96} For moderate to severe depression: psychological therapy as a first-line treatment (eg, individual CBT, interpersonal therapy or shorter-term family therapy) for at least three months.^{49, 96} Antidepressant medication (selective serotonin reuptake inhibitors or SSRIs) may be considered, particularly for adolescents, but only in combination with psychological therapy and if there is no response to psychological therapy after four to six sessions.^{5, 96} If the child or young person is still not responsive, then an alternative psychological therapy, family therapy or individual child psychotherapy may be considered. Advice on exercise, sleep and nutrition may also help.⁹⁶
Anxiety and phobias including obsessive-compulsive disorder (OCD) and body dysmorphic disorder (BDD)	<ul style="list-style-type: none"> Behavioural therapies and CBT, sometimes involving family or carers (particularly if the child is under 11 or there is high parental anxiety), or Exposure and Response Prevention (for young people with OCD or BDD who have not responded to guided self-help).[*] However, CBT only appears to be effective in 50% of cases treated in randomised controlled trials.⁵ Antidepressant medication (SSRIs), usually in combination with a psychological therapy, may be used for social anxieties, OCD or BDD that have not responded to CBT.^{5, 98} The provision of information, advice and support at school may also be helpful.^{5, 49, 98}
Post-traumatic stress disorder (PTSD)	<ul style="list-style-type: none"> Trauma-focused CBT, adapted to suit the child or young person's age, circumstances and level of development.⁹⁹ Eye Movement Desensitisation and Reprocessing (EMDR). However, there has been limited research into this to date. EMDR involves focusing on a particular physical action while thinking about the traumatic experiences in order to change the individual's thoughts and feelings about those experiences.¹⁰⁰
Conduct disorders including oppositional defiant disorder (ODD)	<ul style="list-style-type: none"> Group parent-training programmes led by a therapist, particularly for less severe conduct problems (see Box 10 and Glossary).¹⁰¹ On average two-thirds of children under 10 years whose parents take part show improvement, with effects detectable for up to four years. Parent training for conduct disorders in adolescents seems to have limited effectiveness.⁵ Problem-solving and social skills training. This may be helpful if used in combination with parent training for 8–12 year olds, or where problems are more severe.¹⁰⁰ However, the benefits may be short-term.⁴⁹ Family therapy for adolescents and young people with moderate conduct problems, combined with CBT where appropriate.^{5, 100} Multisystemic therapy (MST). MST is an intensive programme that involves a therapist working with a family in their home to help them change their behaviour patterns, resolve conflicts, introduce rules that will improve the conduct of their child, and reduce opportunities for delinquent behaviour. It is probably the most effective treatment for adolescents with severe and enduring problems.⁴⁹ Therapeutic foster care with trained and experienced foster parents can help children and young people with severe and enduring problems. Medication may help in particular cases, after other forms of treatment have been tried and where conduct disorders are associated with hyperactivity.^{5, 100}
Attention-deficit hyperactivity disorder (ADHD)	<ul style="list-style-type: none"> Parent-training programmes (developed for the management of children with conduct disorders) as the first-line treatment for pre-school children. It should also be offered to the parents of school-age children and young people with moderate ADHD. Parent training/education can improve a child or young person's compliance, boost parental self-esteem and reduce parental stress, although it is not effective in all cases. It may also be used in combination with a group or individual treatment programme (such as CBT or social skills training) for the child or young person.^{5, 49, 100, 102} Stimulant medication as the first-line treatment for school age children and young people with severe ADHD. Research shows it can reduce hyperactivity and improve concentration in 75% of treated children. However, it may lead to mild growth suppression, particularly when used for continuous treatment, so breaks are advisable.⁵ It should always form part of a comprehensive treatment plan that includes psychological, behavioural and educational advice and therapy. Parents should also be offered a group-based parent-training programme.¹⁰² Changes to diet and nutrition (for example, avoiding foods that contain high levels of sugar and artificial colourings, and carbonated drinks) may help some children and young people. ADHD has been linked to deficiencies in essential fatty acids, and there is evidence that taking Omega-3 and Omega-6 fatty acids has a positive effect on reading and spelling and ADHD-related behaviours. Similar links have been found between ADHD and iron, zinc and magnesium deficiencies.^{5, 32} However, NICE guidance does not recommend elimination of artificial colouring and additives from the diet, or taking fatty acids, as a 'generally applicable treatment'.¹⁰²

^{*} Exposure and Response Prevention (ERP) works on the principle that if you stay in a stressful situation long enough, you become used to it and your anxiety decreases—ie, you gradually face the situation you fear (exposure) but stop yourself from doing your usual compulsive rituals (response prevention) and wait for your anxiety to pass.⁹⁷

Mental health disorder / symptom	Recommended treatments
Schizophrenia	<ul style="list-style-type: none"> Medication (eg, anti-psychotic medicines called ‘atypical neuroleptics’) as the primary form of treatment. Specialist care (eg, support from crisis-resolution and home-treatment teams). Psychological therapies, particularly CBT and family therapy (these have been found to benefit adults with psychosis but less is known about how much they help younger people).^{100, 103}
Bipolar disorder	<ul style="list-style-type: none"> Medication (eg, lithium, neuroleptics or mood stabilisers) as the primary form of treatment.⁴⁹ Psychological therapies may also be used as part of treatment, eg, to manage depressive symptoms.¹⁰⁴
Eating disorders	<ul style="list-style-type: none"> Anorexia nervosa: psychological therapies (such as CBT, cognitive analytic therapy (CAT), interpersonal psychotherapy, psychodynamic psychotherapy); family therapy focused specifically on eating disorders; and inpatient care, as necessary, including psychological or behaviour therapy that focuses on eating behaviour, attitudes to weight and shape, and wider issues.^{5, 105} Bulimia nervosa: self-help in the first instance, and a trial of an antidepressant drug may also be offered as an alternative or additional first step; family therapy; and a specific form of CBT for bulimia (CBT-BN), adapted to suit the patient’s age, circumstances and level of development, and involving their family as appropriate. Interpersonal psychotherapy or other psychological treatments may be considered as an alternative, but further research is needed into their effectiveness.^{5, 105} For both anorexia and bulimia: behaviour therapy may also be used with children and young people who are being treated in hospital to help them put on weight.¹⁰⁰ Treatment must involve the management of physical aspects of the condition as the risk of morbidity is high.¹⁰⁵
Deliberate self-harm	<ul style="list-style-type: none"> Specific advice on self-management of superficial injuries, harm-minimisation techniques and alternative coping strategies for people who repeatedly self-injure.³³ Eg, helping young people to distract themselves from self-harm by using a red water-soluble felt tip pen to mark their skin, rather than cutting themselves.³ Developmental group psychotherapy with other young people who have repeatedly self-harmed may be effective in reducing repetition.^{5, 33} Family therapy may help in addressing the issues that cause self-harm.¹⁰⁰
Substance abuse	<ul style="list-style-type: none"> Family therapy and MST may be effective in reducing substance abuse and tackling related problems.^{5, 49} Motivational interviewing, a form of counselling in which the counsellor discusses with the child or young person the advantages and disadvantages of changing his or her behaviour, may be effective, and also preventative programmes in schools that build personal, social and resistance skills.^{5, 100}

The skill of the therapist

Type of treatment is clearly important, but the skill of the therapist is key, especially in the use of psychological or ‘talking’ therapies. As one expert put it: *‘There are some people who just seem to be able to heal troubled children, no matter what therapy they use.’*¹⁰⁶

In one survey, the great majority of mental health practitioners said that they saw the ‘therapeutic relationship’ as the most important determinant of success.¹⁰⁷ An analysis of studies on the therapist–patient relationship in CAMHS backed this up, demonstrating that children who have a good relationship with their therapist are more likely to have a positive outcome from therapy, independent of other factors such as their age and the type of therapy.¹⁰⁷

This is hardly surprising: a child who trusts his or her therapist is more likely to be receptive to treatment and less likely to drop out. As the Department of Health noted in an advice leaflet: *‘Talking therapies are more likely to work if you feel comfortable and at ease with your counsellor, psychotherapist or group leader. So, finding the right person for you is as important as finding the right type of therapy.’*¹⁰⁸

As the rapport between therapist and patient is so important, there is a case for involving children and young people in the recruitment of therapists in order to ensure that they are approachable and ‘young person friendly’. There is also a clear case for allowing an element of choice: if a child or young person does not get on with one therapist, he or she should ideally be able to switch to another. However, there is a serious shortage of therapists in the UK, so this is not always an option—young people are lucky if they get an appointment with a therapist, and frequently have to wait for months to be seen. We will discuss what government and charities are doing to address these issues in Chapters 3 and 4.

The skill of the therapist also lies in their ability to identify the needs of the child or young person they are treating, and to work out which therapeutic approaches will best meet those needs. Experienced therapists tend to pick and choose from a variety of different therapeutic approaches to fit the needs of the individual they are treating.¹⁰⁹



Photograph supplied by the Medical Foundation for the Care of Victims of Torture

Other forms of therapy

Art, music, drama, dance and play therapies are also used in the treatment and care of children and young people. They may be particularly valuable in helping children and young people to express difficult emotions that they would otherwise struggle to put into words. For example, play therapy is widely used as part of the treatment for children who have been abused, and children with developmental and behavioural problems. Research suggests that it is as effective as non-play therapies.¹¹⁰ To find out more about music therapy, readers might like to refer to NPC's music report, *Striking a chord*, which highlights its benefits for particular groups, such as sexually-abused children and people with schizophrenia.^{111, 112} Overall, research suggests that music therapy is more effective with behavioural and developmental disorders than emotional disorders.⁸⁸

These therapies can also provide a good way of engaging children: play- and art-based therapies may seem less intimidating than a

one-on-one conversation with a therapist or psychiatrist. Creating music, theatre and art can also give children and young people a sense of achievement and build their confidence.*

Broadly speaking, the evidence for these therapies is more limited than for talking therapies.⁸⁸ It tends to be based on studies of their use in specific settings and circumstances. This is valuable but makes it difficult to separate the results of these therapies from their context; the evidence base for their effectiveness needs to be developed further. Charities that use these therapies can contribute to this by monitoring and evaluating their results carefully.

Gaps in the evidence

There are still significant gaps in the evidence base about what works in treating mental health disorders. The evidence about what works is much more developed for some disorders than others. For example, there have been more RCTs into treatments for depression and phobias than for post-traumatic stress disorder and bipolar disorder.¹¹³

In many cases, treatment is still quite experimental and further research is needed. There may also be a gap between results achieved by a therapy in the context of research, and the results of therapy in the context of routine practice. This highlights the importance of rigorously evaluating routine practice, so that practical applications can be reviewed and refined.

A table outlining research needs in relation to specific disorders is included in Appendix 2 on NPC's website. The broader gaps in the evidence base are discussed below.

What works in terms of psychological therapies

Since the 1960s the number of different types of therapies has grown enormously: from approximately 60 to over 250.¹⁰⁹ This can make it difficult to decide which types of therapy are most appropriate for any given individual or disorder.

NPC has been particularly struck by the limited evidence comparing the effectiveness of different forms of psychological (or 'talking') therapies, their use with different disorders, and in different settings. This is partly because the nature of the therapies makes them difficult to compare. For example, CBT is more directive and structured than many forms of psychotherapy; this makes it easier to measure (see Box 11). It also reflects the fragmentation of the sector between therapists from different ideological schools.

Box 10: The benefits of parent training

Loretta is a single mother whose ten-year-old son was out of control and getting in trouble with the police. She also had her own problems: as a child, her own father was rarely around, she had been sexually abused and had tried to commit suicide twice.

Through the charity **Family Action**, Loretta was invited to take part in a parenting programme. Although at first she found it difficult, after a couple of sessions she started to value the opportunity to meet and share her problems with other people with similar experiences. She feels the programme has been a turning point in her relationship with her son: *'If it weren't for the parenting course I don't know where I'd be. I mean, we was coming to fist fights, both of us. Whereas now I can talk to him, like I talk to any adult. It made me realise that he has got a point of view. He's doing well at school; he's like a different child. We're getting along so well.'*

Certain types of therapies seem to be more effective with specific conditions. Further research is needed on this, particularly in relation to children and young people. In addition, the effectiveness of telephone and online delivery of therapies such as CBT needs rigorous evaluation.

Also, the outcomes of therapy are not simply determined by the type of therapy used. Further research into the relative significance of other factors, such as the relationship (or 'alliance') between the therapist and their client, and the client's level of engagement and ability, would be valuable.^{20, 109, 114}

What works for black and minority ethnic groups

There is limited data on how effective treatments are when used with children and young people from black and minority ethnic (BME) groups.⁵

This is a major gap: almost 8% of the UK population come from BME groups, or 4.5 million people, according to 2001 census data. The proportion is higher for children and young people: one in five of the total population under the age of 20 comes from a BME group.¹¹⁵ Overall, the prevalence of mental health disorders seems to be slightly higher in BME than white children (12% as compared to 10%), although it varies between different BME groups.¹¹⁶ Research has also found that BME groups face particular difficulties in accessing mental health services.¹¹⁵

What works in terms of self-help

Further research is needed into the most effective forms of self-help, including real and virtual self-help groups and computerised CBT, which may be used for specific conditions, such as depression, anxiety and OCD.

Without careful monitoring, there is a risk that self-help groups and web forums comprised of sufferers might offer an environment in which negative behaviour could be shared or perpetuated. In a minority of cases self-help groups have a negative effect on sufferers. With eating disorders, for example, there is sometimes competition between group members about their weights and caloric intake, which can motivate group members to stay ill rather than seek help with recovery.

A recent survey found that 37% of 12–18 year olds would turn to the internet first for mental health advice.¹² As computers grow ever more accessible, computerised forms of self-help may become increasingly important in the treatment of specific disorders, and could ease the pressure on health professionals. They may provide more discreet and accessible

Box 11: What is cognitive behavioural therapy?

Cognitive behavioural therapy (CBT) is a term that covers a number of therapies that are designed to help solve problems in people's lives, such as anxiety, depression or post-traumatic stress disorder. A course of CBT therapy might consist of 5–20 weekly sessions, with each session lasting between 30–60 minutes.

It is based on two earlier forms of psychotherapy: cognitive therapy, which aims to change people's thoughts, beliefs, attitudes and expectations; and behavioural therapy, which is used to change the way people act. CBT works on the premise that we need to change both the way we think and the way we behave at the same time. Although external events can cause problems, we can learn to change our response to these events and manage our unhappiness and stress.

CBT is more structured and pragmatic than most other forms of psychotherapy. For example, the therapist and his or her client will work together to identify a specific problem, break it down into smaller parts and then set goals to work towards. This may involve homework in the form of activities to try or techniques to use before the next therapy session. CBT is also focused on the present, whereas some other therapies concentrate on exploring and resolving past issues.⁹

CBT is currently very fashionable and is being championed as part of the government's *Improving Access to Psychological Therapies (IAPT)* programme in England (see Chapter 4). The fact that it is structured, short-term and goal-oriented makes it attractive to policy-makers and, arguably, easier to measure than some other forms of psychotherapy. However, some academics have warned that the idea that CBT is more effective than other talking therapies is a myth.

In a joint statement published on 7 July 2008, a group of academics commented that: *'The government, the public and even many health officials have been sold a version of the scientific evidence that is not based in fact, but is instead based on a logical error.'* They expressed their concern that the focus on CBT has negative consequences for other well-developed psychotherapies, such as person-centred and psychodynamic psychotherapy, which are just as effective but have smaller evidence bases. They also commented that, *'Such claims harm the public by restricting patient choice and discourage some psychologically distressed people from seeking treatment.'*²⁰

NPC's view is that CBT is an effective form of treatment for many conditions, but it is not a panacea, as it is sometimes presented. Whilst greater provision of CBT is welcome, therapists will need to be properly trained and there also needs to be greater access to, and evaluation of, other forms of therapy.

ways of getting support for young people who are concerned about confidentiality or stigma. New technologies also offer new opportunities for reaching out to young people. For example, the popular social networking site Bebo has developed a 'Be Well' centre, through which users can access expert advice from organisations including NHS Direct, Samaritans, and ChildLine, and specialist charities like **beat** (about eating disorders) and **Beatbullying** (about bullying in school).¹¹⁷

However, sites such as Bebo have the potential to spread the wrong sort of influences (such as suicide cults) and need to be monitored and regulated very carefully. The evidence base for their impact on children and young people's

“Young people don’t want to sit in an office and talk about what’s gone wrong with their life and come away with an appointment for three weeks’ time.”

“When we go for help, it would be good if as many people as possible would help us get a bit of control back in our lives.”

mental health is currently limited; charities and donors could help by carrying out evaluations.

NICE has approved the use of particular computerised CBT packages for adults. However, more evidence is needed on their use with different age groups and ethnic communities, and their effectiveness in comparison to other forms of self-help.¹¹⁸ Computerised programmes specifically for children have been developed and are in the process of being evaluated.¹¹⁹

The role of helplines

The effectiveness of telephone, text message and email helplines in supporting children and young people with mental health problems needs to be evaluated further. Charities such as **Samaritans** are playing an influential role in developing these technologies for children and young people. Their work will be discussed in Chapter 4.

The role of exercise

There is strong evidence of a positive association between physical activity and mental health, but not necessarily a causal link. Research into adult mental health has suggested that exercise can have a positive impact on the management of stress, anxiety and depression, and other mental health issues. However, more research is needed on the role of exercise in children and young people’s mental health.¹²⁰

The role of nutrition

There is clear evidence that nutrition and biochemistry have a crucial impact on the development of a child’s brain and nervous system. Food supplements or special diets may therefore have an important role to play in preventing and treating mental health problems.

To date, research on the links between nutrition and mental health has tended to focus on adults. For example, research trials have suggested that the fatty acid known as Omega-3 may improve the symptoms of mental health disorders such as schizophrenia and depression in adults. Omega-3 is needed for the structure of every membrane in the brain and improves the speed of neural transmissions, but, in developed countries, it is often lacking in our diets.⁴⁰ Further research is required to assess the importance of Omega-3 to children’s development.

There is some promising evidence about the impact of nutrition on conduct disorders. A study of 231 young offenders in a high security unit suggested that the introduction of multivitamins and fatty acids in their diet contributed to a reduction in antisocial behaviour incidents overall. There was a 34% reduction in antisocial behaviour among

those who took the supplements for at least two weeks, and a 37% reduction in violent offences.¹²¹

Hyperactivity and learning problems have also been associated with food additives and natural ‘salicylates’ (acids found in many foods and cosmetics). However, much more research is required into the most effective diets or supplements to address this. Sensitivity to particular nutrients or additives varies from child to child, and the preparation of special diets can be arduous.^{34, 120}

What children and young people need

A significant gap in the literature on what works is data about what children and young people want from mental health services. In addition to their ethical right to be consulted, treatment that does not take their perspective into account is less likely to be effective. If children and young people do not feel comfortable with the treatment they are receiving, there is a greater risk that they will resist therapy or drop out.

As one 19 year old commented: *‘When you are younger, you sometimes don’t have any control over what people do to you. Sometimes people have done things to your body and your mind that you wished they hadn’t. That’s why a lot of young people get ill. When we go for help, it would be good if as many people as possible would help us to get a bit of control back in our lives. By allowing us to make choices about who we see and what treatment we access, and by being honest with us, we can make choices which will lead to us getting better more quickly without wasting our time or money.’*¹²²

Yet children and young people have rarely been consulted in the development of statutory services or choice of treatment.⁴⁹ As we will see in the next chapter, many children and young people say that doctors and therapists do not involve them in decisions about their treatment. As a result, they feel confused, scared and isolated.

This situation is now beginning to change, in large part due to the work of charities. Research from charities such as **YoungMinds**, **Mental Health Foundation** and **Youth Access** has highlighted the perspectives of children and young people and problems with existing services. This is discussed further in Chapter 4.

Primary school children

YoungMinds held focus groups with primary school children to investigate what they associated with happiness and sadness. These consultations suggested that children saw bullying as the greatest cause of unhappiness, which tallies with research into bullying as a risk factor, discussed in Chapter 1.

The focus groups also confirmed that primary school children are more likely to go to their family for help in the first instance. This again points towards the importance of parent training and improving parents' awareness of mental health problems.

Children do not tend to associate anger or unhappiness with a need for therapy or adult support. When asked what would make them happier, pets and chocolate were the most popular answers. They said that listening to music was the best way to calm down.¹²² These observations help to improve our understanding of what motivates young children, although they may have limited relevance for the development of treatments.

Adolescents and young adults

The **Mental Health Foundation** interviewed over 200 16–25 year olds for its *Youth Crisis* and *Listen Up!* projects to find out what sort of support they were looking for. Children and young people stressed that they wanted to be seen as 'individuals, and not a collection of symptoms' and would like mental health services that:

- are delivered in a friendly, flexible, understanding, safe and confidential environment;
- provide immediate and sensitive support for young people who are particularly vulnerable or in crisis;
- provide support that is not judgmental or stigmatising, from skilled staff who treat them with respect and equality;
- involve young people in staff training;
- allow an element of choice, whether in terms of the therapist they work with or the type of treatment they receive;
- offer opportunities to explore their individual needs and preferences, to escape, to have fun and be creative, eg, through organised activities such as art, music and drama or day trips;
- offer opportunities to make new friends, eg, through informal group activities that give them the chance to meet peers who have had similar experiences and build a social network;
- offer opportunities to improve self-confidence and develop skills that will be useful in education, work and social settings; and
- provide a range of support, advice and information that meets other needs that may be associated with their mental health, eg, sexual health, finance, housing, education and employment.¹²³

Services need to be accessible in terms of ease of referral, location and timing of support. As one young person put it, *'There's no point*

having a service available between nine and three on a Monday, Wednesday and Thursday. I need to know where to go for help when it's just me and four walls on a Sunday night.'¹²⁴

Emergency response services are improving, though they could be improved further. In 2007, 82% of NHS provider trusts with CAMHS provision had an on-call service with a response by specialist CAMHS professionals. However, only 54% of these were exclusively CAMHS.¹²⁵ The situation appears to be worse for adults. A 2008 survey, which canvassed the opinion of 14,000 16 to 65 year olds, showed that 45% of people using mental health services did not even have access to a crisis number to call out of office hours.¹²⁶

Support needs to be provided in places where young people spend time, such as schools, youth clubs and high streets, which means improving the knowledge and skills of staff in these places. The manager at **Barnardo's Marlborough Road Partnership**, one of the projects involved in *Listen Up!*, commented: *'What doesn't work is fixed times in fixed places with people who know lots in theory about mental health but don't have the time or the capacity to truly make a difference. They [young people] want flexibility: a service that isn't just about mental unwellness; one that can help them with their housing and benefits, go shopping with them, go to the pictures with them and talk about their anxiety and depression. They don't want to sit in an office and talk about what's gone wrong with their life and come away with an appointment for three weeks' time.'*¹²⁷

YoungMinds' focus groups with 14–19 year olds also found that, while primary school children were more likely to go to their family for help, teenagers tend to go to their peers for support.¹²² This highlights the importance of improving young people's awareness of mental health problems and what they should do to help a friend in need. This has not traditionally been a priority for policy-makers.¹²

The best way to ensure that mental health services meet children and young people's needs is to involve them in the development and evaluation of these services. The very process of involvement can benefit children and young people's mental health, by giving them a sense of control and building their confidence. This is illustrated further in Chapter 4.

Messages for charities and donors

Charities can play a vital role in developing the evidence base for the treatment of mental health problems by: lobbying the government to invest more in research; carrying out their own research; evaluating the results of treatments and therapies that they deliver; and ensuring that children and young people are consulted for all of the above.

I need to know where to go for help when it's just me and four walls on a Sunday night.

Young people want 'a service that isn't just about mental unwellness'.



Photograph supplied by Family Action

In particular, charities might think about evaluating treatments in terms of:

- specific mental health problems;
- specific times and places where the treatments are provided; and
- specific groups of children and young people.

As we saw in the case study at the start of this chapter, mental health problems are complex and there is rarely a simple solution. Organisations supporting children and young people therefore need to take a flexible, adaptable approach, and charities often have greater freedom to do this than government services.

Donors can support the development of the evidence base for effective treatment by funding

charities with a good track record of research and evaluation, or funding a well-respected academic institution to carry out primary research. This represents an opportunity to make a very real difference to the sector. Options for donors will be discussed in more detail in Chapter 6.

In the next two chapters we will put the evidence about what works into context, by examining what government and charities are doing on the ground. As we will see, there is often a mismatch between theory and practice. Disseminating, implementing and evaluating new guidelines and programmes is expensive and time-consuming, and the sector's financial and human resources are very limited. Charities and donors can make a vital contribution to this process.

What is government doing?

Historically, government mental health services have been severely overstretched and focused on treatment rather than prevention. Over the last decade, a shift in policy and increased investment have started to broaden this approach. It is now generally accepted that mental health is ‘everybody’s business’ and that a wide range of professionals must work together to meet the needs of children and young people.

However, there are many challenges to achieving this. There is no clear champion for the sector in government and overall, the state—through GPs, mental health services, schools, social services—still does not have the resources to reach all children and meet all needs. There is considerable uncertainty over the future level of funding for Child and Adolescent Mental Health Services (CAMHS), which is currently under review. Imperfect co-ordination between government agencies at a local level, and government departments at a national level, also reduces the effectiveness of well-intentioned policies.

By articulating what government is doing, and illustrating what it does well and what others might do better, NPC hopes to help charities and donors determine where to concentrate their efforts and fill the gaps.

Role of government

The role of government in supporting children and young people’s mental health has been re-defined over the last decade. New international commitments have encouraged governments across Europe to raise their game. In 2005, the World Health Organisation published a *Mental Health Action Plan and Declaration for Europe*, which made the improvement of children and young people’s mental health one of its priorities. In June 2008, the European Commission launched a Mental Health Pact, with ‘youth, education and mental health’ as one of its main themes.¹²⁸

This has been reflected by policy changes in the UK. Until the 1990s, children and young people’s mental health was seen as the preserve of specialists working in a low-profile and under-resourced arm of the National

Health Service. Now it is increasingly seen as ‘everybody’s business’. As well as being the focus of specialist Child and Adolescent Mental Health Services (CAMHS), the mental health of children and young people is viewed as the responsibility of GPs, schools, parents, social services and other individuals and organisations who come into contact with children and young people on a daily basis.

This chapter explores what the governments in England, Scotland and Wales are doing to improve children and young people’s mental health. It discusses the policies and initiatives coming out of central government, and how this translates into direct services for children and young people at a local level.

The aim is to provide a brief overview of government provision and policy in order to determine the role of charities and where their services are most valuable. However, some readers may prefer to go straight to the end of the chapter to view NPC’s analysis of the gaps in provision, or go to Chapters 4, 5 and 6, which directly discuss the charities working in this sector and our funding recommendations.

Who is responsible in central government?

In practical terms, children and young people’s mental health mainly falls within the remit of two government departments: health and education. Yet it has broader implications for the criminal justice system, employment, sick pay and incapacity benefits. It is also a priority for the Children’s Commissioners in England, Scotland and Wales, who are charged with representing children and young people’s views and interests at a national level.

In England, children and young people’s mental health is the responsibility of the Department for Children, Schools and Families (DCSF) and the Department of Health (DoH). It was identified as a priority in the *Children’s Plan*, published by the DCSF in 2007. The *National Services Framework for Children, Young People and Maternity Services*, published by the Department of Health in 2004, includes detailed recommendations on the ‘Mental Health and Psychological Well-being of Children and Young People’. The DCSF and the DoH are also due to publish a child health strategy in late 2008.

Children and young people’s mental health is increasingly seen as ‘everybody’s business’.

It is difficult to identify an accessible champion for the sector in government.

Their roles, with regard to children and young people's mental health, can be summarised as follows:

- **The DCSF** focuses on promoting emotional well-being and providing support for vulnerable young people through schools, *Sure Start* children's centres and other educational institutions. However, it appears to be quite thinly spread in managing its initiatives and liaising with the Department of Health and charities.
- **The Department of Health** focuses on the treatment of mental health problems. It funds specialist CAMHS and Adult Mental Health Services (AMHS), specific initiatives across the NHS, and specialist work by some charities. It also works in partnership with the DCSF on targeted prevention and early intervention programmes.

Overall, NPC found it difficult to identify an accessible champion for the sector in government that charities can turn to in order to discuss issues and strategies for specific problems.

In Scotland and Wales, the situation is broadly similar. Both nations have CAMHS and AMHS, and Children's Commissioners who are active in promoting children's mental health. However, there are various initiatives that are specific to Scotland and Wales, which are discussed later in this chapter.

Who delivers services?

At a local level, the government provides support for children and young people through specialist CAMHS and AMHS, which are run by Primary Care Trusts (PCTs) and Mental Health Trusts. But some CAMHS services are delivered by other partners, eg, local authorities and charities.

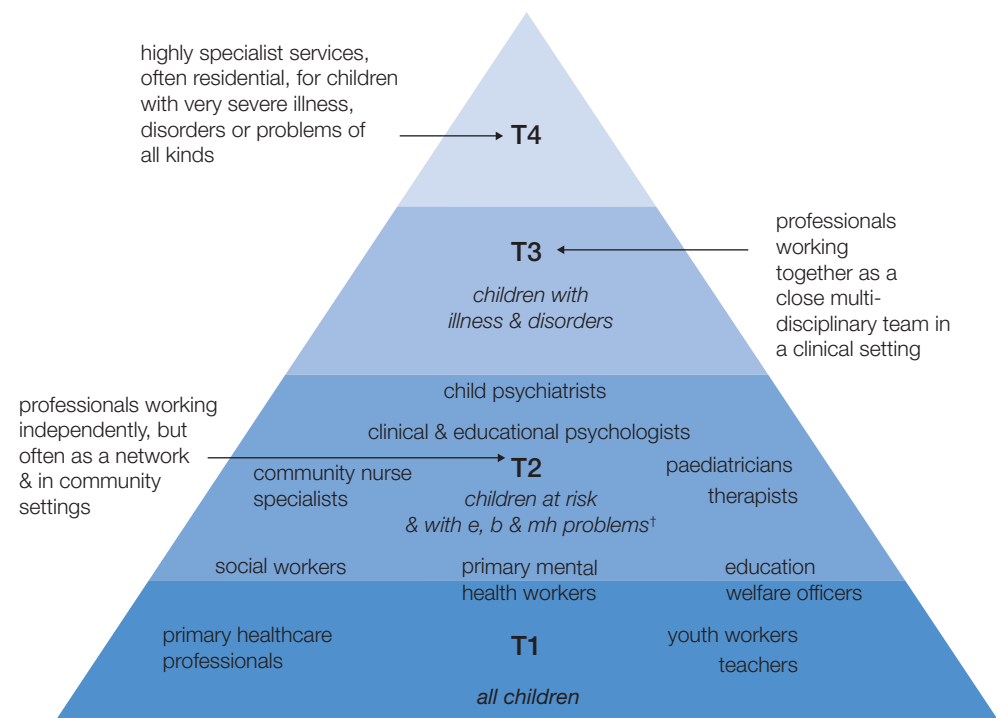
Mental health services have long suffered from severe under-funding. Mental health was, until recently, seen as the 'Cinderella' service of the NHS. CAMHS were a low-profile offshoot of this and struggled to attract the same level of investment as adult services.¹²⁹ This has had a serious impact on the quality and quantity of research into child and adolescent mental health, and on the availability of treatment.

Child and Adolescent Mental Health Services (CAMHS)

CAMHS are responsible for the mental health of children and young people up to the age of 17 or 18 in England, Scotland and Wales. They provide a spectrum of services, which range from preventative work to psychiatric treatment in specialist residential units.

This spectrum is represented in the 4-tier model of support shown in Figure 2. Introduced in 1995, the 4-tier model was designed to encourage a shift from CAMHS as a specialist

Figure 2: The 4-tier structure of comprehensive CAMHS*



[†] emotional, behavioural & mental health

Source: Charman, S. (2004) *Mental health services for children & young people: the past, present and future of service development and policy*. Framework Feature in Mental Health Review, 9 (2).

service for children with severe disorders, to a comprehensive partnership of agencies that work together to pick up mental health problems at an earlier stage. It represents a shift in approach that goes beyond a focus on health to include other sectors such as education and social care. In this report, we distinguish between 'comprehensive CAMHS', which we will use to refer to all four tiers, and 'specialist CAMHS', by which we will mean Tiers 2, 3 and 4.

The government delivers nearly all of the specialist Tier 3 and Tier 4 services, which includes inpatient units and crisis teams. Specialist professionals are also found in Tier 2 services. Examples of the different types of professionals working in CAMHS are outlined in Box 12.

Work at Tiers 1, 2 and 3 is sometimes contracted out to charities and local organisations, such as youth information, advice, counselling and support services (known as YIACS and described in more detail in Chapter 4), and charities working in schools. Local authorities and PCTs often commission charities (such as YIACS) to help deliver support in the community.

The primary healthcare professionals referred to in Tier 1 include GPs and school nurses. They are often the first point of contact for children and young people experiencing mental health problems. However, not all children and young people feel comfortable seeking help from these professionals. Some may not recognise they have a problem, or are ashamed to admit it, while others find going to their GP intimidating.

There is a strong case for developing the broader educational and social workforce so that they are better able to identify emerging mental health problems and have the confidence and skills to provide basic support. Charities can play an important role in this training, as we will see in Chapter 4.

Challenges

The quality of service provision is also patchy. CAMHS do not fit comfortably within the NHS structure, and the way they are organised varies from area to area. In some areas, CAMHS are run from the local adult mental health trust. In others, CAMHS might have their own place within the local PCT. For CAMHS to run effectively, there need to be good links between professionals working at the different tiers. This often relies on the strength of relationships between individuals.

Box 12: Children and young people's mental health specialists

The roles of different professionals who treat young people with mental health problems can be confusing. The main groups are outlined below.

Child and adolescent psychiatrists: are trained to diagnose and treat a wide range of mental health disorders in children and young people. They have the authority to prescribe drugs and may use a variety of different therapies.

Psychiatric nurses and health visitors: are trained to treat the physical and emotional aspects of children's problems.

Clinical psychologists: are qualified to carry out psychological tests to assess children's personalities, competencies and problems, and provide therapy, but do not have the authority to prescribe drugs.

Educational psychologists: usually come from teaching backgrounds but have done additional training in educational psychology and are qualified to use psychological tests. They tend to focus on learning difficulties and social and emotional problems that affect children and young people in schools, colleges, nurseries and special units. Their reports may inform the allocation of special educational places, court proceedings or children's panels.

Child and adolescent therapists: may be trained in a number of different types of therapy, including psychodynamic psychotherapy, cognitive behavioural therapy, and person-centred therapy (see glossary for definitions).¹⁰

The fragmented nature of CAMHS makes it difficult to determine how best to improve services nationally. Three national organisations have been set up to improve the way CAMHS works in England: the CAMHS Evidence-Based Practice Unit (EBPU); the CAMHS Outcomes Research Consortium (CORC), which also has members in Scotland and Wales; and the National CAMHS Support Service (NCSS). These are discussed in Box 13.

National charities such as YoungMinds are also involved in policy consultations about CAMHS, but there is no easy fix. Donors and charities often find that they have to approach the problem at a local level, particularly as funding for CAMHS is also increasingly devolved.

Current and future funding

The shift from specialist to comprehensive CAMHS has been accompanied by an increase in funding in recent years, rising year-on-year from £322m in 2003/2004 to £523m in 2006/2007.¹¹⁹ This budget covers children and adolescents in England up to the age of 18, at which point young people are passed on to adult services.¹¹⁹

It takes time to build successful services and, despite increased funding, CAMHS remain overstretched. If they are to fulfil the government's objective of intervening at an earlier stage, more resources are needed.*

* Readers who are interested in finding out more about how this money is allocated across the country should refer to the website that provides information about the government's mapping of CAMHS and other children's services: www.childrensmapping.org.uk.

Box 13: Improving the way CAMHS works

Since 2002, three organisations have been set up in association with CAMHS to promote and develop good practice and coordinate its implementation.

The CAMHS Evidence-Based Practice Unit (EBPU)

The EBPU is an academic unit that forms part of University College London and the Anna Freud Centre, a charity that will be discussed further in the next chapter. The objective of the EBPU is to promote best practice by increasing understanding among professionals of the evidence about effective treatment within CAMHS. It also advises them on how to evaluate the outcomes of their work, how to interpret evidence and how to review and improve their practice. It is currently involved in a collaborative research project on strengthening links between educational institutions and child and adolescent mental health providers, and the evaluation of the government's *Targeted Mental Health in Schools* initiative.

For more information see www.annafreudcentre.org/ebpu.

The CAMHS Outcomes Research Consortium (CORC)

CORC is an independent membership organisation of CAMHS services from across the UK. Working closely with the EBPU, its objective is to develop and then support members to disseminate a common model for systematically evaluating results across CAMHS. CORC aims for data to be collated and analysed centrally, and used by commissioners, providers and users of CAMHS. Over half of CAMHS services in England are members of CORC, and there are also members in Wales, Scotland and Norway.

For more information see www.corc.uk.net.

The National CAMHS Support Service (NCSS)

The NCSS is funded by the Department of Health and the DCSF to support the implementation of a comprehensive approach to CAMHS, from health promotion to more specialist provision. The service employs regional development workers who liaise with relevant agencies at a local level to ensure that services are delivered in a coordinated way. Current priorities include: perinatal and infant mental health; learning disabilities; improving access to inpatient care; developing commissioning; providing appropriate care for 16–18 year olds; supporting transitions from CAMHS to AMHS; and involving children and young people in service development.

As Table 5 shows, the CAMHS budget represents only 10% of the government's expenditure on AMHS in England.¹³¹ If we assume that one in six adults has a mental health problem at any one time, the spend per affected adult is 60% greater than the spend per affected child. Given that many children's mental health problems will endure into adulthood, and these problems are best tackled in their early stages, NPC believes that there

is a strong case for increasing the spend per affected child.

Historically, specialist CAMHS received funding from PCTs and local authorities ('joint commissioning'), via a 'ring-fenced' CAMHS grant. Ring-fencing meant that each CAMHS was certain of a precise level of funding designated for its services.

However, the funding model changed for 2008/2009: specialist CAMHS funding is no longer ring-fenced, and has become part of generic area-based funding channelled through PCTs and local authorities. This means that PCTs and local authorities no longer have to spend a specific amount on CAMHS,¹¹⁹ although they do have to reach delivery targets. Given the historical neglect of the sector, there is a risk that child and adolescent mental health targets will suffer amongst competing local priorities.

These funding changes have arisen from a drive to decentralise spending and policy. However, there is widespread concern in this and other sectors (ranging from housing to disability services), that local government agencies do not yet have the capacity to implement these reforms. Donors need to be aware that the current uncertainty around commissioning may mean that local charities face higher levels of financial risk. This will be discussed in more detail in Chapter 5.

CAMHS Review

The government has commissioned an independent review of CAMHS, which is due to be published in November 2008. No further funding is likely to be announced before then. However, an interim report was published in July 2008, which provides a clear and self-critical analysis of what is and is not working.[‡]

The interim report stresses that there is still some way to go before a culture of improving psychological well-being becomes embedded in services working with children. It includes many important practical points for improvement, and also highlights promising approaches. The report reflects many of NPC's findings, and is realistic about much of the practical detail. However, the review could potentially have done

Table 5: Funding for adult versus children's mental health services in England in 2006/2007*

	Population	Population affected: %	Population affected: total numbers	Spend £	Spend per head £
Children under 18	11.0m ⁵⁴	10% ^{6†}	1.1m	£523m ¹²⁵	£476
Adults over 18	40.1m ⁵⁴	17% ¹³⁰	6.7m	£5.1bn ¹³¹	£763

* Using mid-2007 population estimates from the Office for National Statistics.

† The 10% prevalence statistic is for 5–15 year olds. A prevalence rate for all children and young people under 18 is not available. However, research suggests that the prevalence of mental health problems in 16–18 year olds is likely to be higher, so 10% can be taken as a conservative estimate.⁵¹

‡ This can be accessed through www.dcsf.gov.uk/CAMHSreview.

more to canvass the opinions of children and young people on their experiences of specialist CAMHS and to discuss the role of the voluntary sector.

The points that NPC found most interesting were:

- Services (schools, local authorities, CAMHS, children's trusts, the youth justice system) are still not sufficiently well linked and often follow different guidelines. This suggests that there is scope for aligning policy better, but also for working harder to improve local relationships in order to achieve objectives. Local accountability and leadership is important, but the relationship between the DoH and the DCSF also 'needs clarifying'.
- Schools have a vital role in children's well-being and could be used more effectively to support children. Some already do this successfully.
- Funding needs to be pooled or aligned better to achieve objectives. Multiple separate budgets may be one of the barriers to helping children and young people. Lack of expertise among commissioners may hamper effective spending.
- More evidence of what works is needed. Monitoring and evaluation is currently focused on processes and structures rather than effectiveness and outcomes. This needs to change.
- A growing evidence base for the value of parenting support (and other interventions) should encourage commissioners and providers to think flexibly about what services are needed. The new National Academy of Parenting Practitioners will help with training and further evidence-gathering.
- Professionals working with children need more skills. Many professionals coming into contact with vulnerable children are unable to help when, with the right expertise, they could.
- Groups that are particularly vulnerable to mental health problems could be targeted earlier before problems emerge.

The report noted that young people are concerned about the way they are stereotyped in the media, and endorsed the role of non-stigmatising and accessible services in reaching children and young people. It also expressed some concern that services do not adequately support the transition from childhood to adolescence and adulthood.⁵³

The final review should lead to some recommendations on how CAMHS can be improved. NPC also believes that charities can

help to solve many of the problems identified in the report. The charities discussed in Chapter 4 are important in: contributing to the evidence base; influencing local commissioners to support best practice; providing training to professionals; working with children in schools; offering accessible, community-based support for teens and young adults; and targeting vulnerable groups.

Adult Mental Health Services (AMHS)

Young people in their late teens are passed from specialist CAMHS on to AMHS. The cut-off point for CAMHS is not consistent across the UK: in some areas it is at the age of 16, whereas in other areas it is 18 or 19.^{123*} In 2006, more than one CAMHS service in five did not have provision for 16 and 17 year olds.^{125†}

Lost in the system

The transition from CAMHS to AMHS is not straightforward and there is a danger that young people may get lost in the system. In 2003, at least 26 out of 88 NHS Mental Health Trusts in the UK did not have written arrangements to ensure that young people were supported in the transition between CAMHS and AMHS.¹³² In some areas, AMHS only start working with young people three years after the local CAMHS cut-off age.¹²³ In addition, young people who were treated by CAMHS do not necessarily fit the criteria for ongoing care from AMHS; for example, young people with ADHD or autistic spectrum disorder might be discharged back to their GP when they reach the age of 18.¹¹

Young people are also often admitted to adult psychiatric beds due to a shortage of space in adolescent units. For example, in 2005/2006, 16 and 17 year olds spent 29,306 'bed days' on adult wards, with 353 'bed days' spent by under 16 year olds. In other cases, they are admitted to paediatric wards, or sent to units outside their area, due to lack of local provision.¹⁴

Inadequate care

Although some young people do experience high quality care on adult psychiatric wards, in many cases they do not receive the type of support that is appropriate for their age group. For example, they may not be treated by staff who are trained to work with young people. They may not have access to education, or the chance to socialise with other young people of a similar age. These issues were discussed in a report called *Pushed into the Shadows*, produced by the charity YoungMinds for 11 Million (the Office of the Children's Commissioner in England). The report drew on

Groups that are particularly vulnerable to mental health problems could be targeted earlier.

Young people are often admitted to adult psychiatric beds due to a shortage of space in adolescent units.

* Central statistics on the numbers of young people who are admitted to adult psychiatric wards is not available.¹⁴

† The only statutory mental health service that spans the transitional age group is the Early Intervention in Psychosis Team, which deals with psychotic disorders such as schizophrenia and bipolar disorder, which tend to emerge in late adolescence or early adulthood.¹²³

Box 14: Young people's experiences of adult psychiatric wards

When he was 17, Jack began hearing voices and thinking that people were touching him. After a mental health assessment Jack was admitted to an adult unit about half an hour away from his home. This was because there was no room in the local young people's unit. After a month Jack was discharged but had to be readmitted five weeks later to another adult unit. He found this much more difficult than the first unit because the patients were much older and the staff did not seem to know how to talk to young people.

Mary began cutting herself and taking overdoses when she was about seven. Living in a rural area, it was very difficult to see anyone from local health services and she remembers really only getting help when she went to university. Mary had her first admission to an adult mental health ward when she was 19 and found this a very unhelpful experience because the ward staff were always so busy that they had no time to talk to her and there was very little to do.

Sam was prescribed anti-depressants in his early teens. At 15 he experienced an acute psychotic episode. His local adolescent unit was full, and since he was told that the only alternative was the local police station, Sam agreed to go to the acute adult facility. He was discharged four days later into the care of his mother while his CAMHS psychiatrist tried to find him a place in an adolescent unit. Sam was finally admitted to his local adolescent unit roughly nine months after his first psychotic episode.

Source: YoungMinds (2007) *Pushed into the shadows: young people's experience of adult mental health facilities*. Office of the Children's Commissioner.^{14, 15}

the experiences of 16 young people, some of whom had spent time on an adult ward when they were as young as 13. Many of them found that they were the youngest person on the ward by some way and consequently found it hard to make friends (see Box 14 for examples).

This report highlighted a number of other causes for concern. Many young people feel that they are not adequately involved in decisions about their treatment or informed about their rights. This exacerbates their fear and leads to confusion about what is going to happen to them, what they should expect, and when they are likely to be discharged. A number of the young people included in YoungMinds' consultation said that they felt isolated and bored during their time on adult wards. Some also felt unsafe, either due to harassment from other patients or intimidation by staff who were not trained to work with young people.¹⁴

What is being done?

In November 2006, the government made a commitment that within two years no young person under the age of 16 would be treated on an adult psychiatric ward. This was followed by a provision in the *Mental Health Act 2007* which stipulated that, by April 2010, all under-18 year olds admitted to inpatient care for mental health treatment in England should be placed in an environment that is suitable for their age, as approved by a CAMHS specialist, and have access to appropriate services, such as education.

In 2007/2008, the Department of Health also allocated £31m of capital funding to 17 projects that aim to eliminate the inappropriate use of adult psychiatric wards for children and young people. This is an average of £1.8m per project.^{119, 133}

A progress report from 11 Million and YoungMinds, *Out of the Shadows*, was published in October 2008. It found that, although inpatient care is improving, there is still a long way to go. Less than 15% of PCTs and Mental Health Trusts surveyed were able to demonstrate that they had eliminated inappropriate use of adults wards for adolescents, or could provide adequate acute (Tier 4) care for emergency admissions, or medium- to long-term planned care of young people. In over three quarters of trusts, not all young people admitted to an adult ward were supported by a professional trained to work with children and adolescents. Less than a third of trusts provided access to education and less than a quarter said they offered daily activities for young people who might otherwise feel isolated and bored.¹³⁴

Once more, NPC would highlight the role that charities can play in supporting the transition from CAMHS to AMHS. YoungMinds lobbied for the change to the *Mental Health Act 2007* mentioned above, and local community charities such as YIACS often act as advocates, liaising with statutory mental health services on a young person's behalf to ensure that they receive some continuity of care.

As with CAMHS, a shortage of therapists is a problem for AMHS. The government is addressing this through its *Improving Access to Psychological Therapies (IAPT)* programme (see Box 15).

Parents and families

In the last decade, the government has invested heavily in parenting and family support programmes. These include the *Sure Start* Children's Centres and a National Academy for Parenting Practitioners. Many of these programmes offer good opportunities for government agencies and charities to work in partnership.

Sure Start

The government introduced *Sure Start Local Programmes* in 1999 as a flagship initiative for tackling child poverty and social exclusion. This initially involved the development of Children's Centres in areas of high deprivation, but by 2010 the government plans that every community in England will have a *Sure Start* Children's Centre.¹³⁵ Centres are the responsibility of local authorities and are run by a partnership of private-sector, public-sector, and, in some cases, voluntary-sector organisations.

Young people
can feel
isolated, bored
and unsafe on
adult wards.

Children's Centres are open to all children under the age of five and their families. The types of services that centres offer vary from area to area, depending on available resources and the needs of the local community. They may include childcare, early years play and learning, parenting advice, healthcare, home visits, job advice and training for parents, and support for children and families with specialised needs.^{135, 136}

A six-year national evaluation of *Sure Start* is underway. Preliminary findings, published in 2005, were at first inconclusive, but a more recent evaluation, published in 2008, shows promising results. Improvements in parenting skills, and children's behaviour and social skills, are starting to emerge. Earlier concerns that the children and families who need support most are not necessarily those accessing the services appear to be partially allayed. However, open access services still need to be balanced with outreach services that are specifically targeted at vulnerable groups. It is also difficult to determine which activities are having the most impact, and children and families accessing the programme need to be tracked for longer to see if the benefits last.^{22, 135}

National Academy for Parenting Practitioners

Established in November 2007, this charity is funded by government to: develop research into parenting; offer training; act as a virtual knowledge hub; and influence policies on parenting.¹³⁷ Readers who would like to learn more about parenting and effective interventions could visit the website: www.parentingacademy.org. It is too early to evaluate its impact.

Schools

The promotion of emotional well-being has long been recognised as an important element of a good education, and closely related to children's academic and personal development. However, until the last decade, schools were not required to meet specific government targets on this. Teachers and other school staff—the professionals who probably spend the most time with children—were not specifically trained to identify mental health issues and lacked the skills and confidence to provide frontline support.

This situation is beginning to change. The government's commitment to improving the emotional well-being of children in schools, as stated in the 2007 *Children's Plan*, is being backed up by a raft of related policies, such as the *Targeted Mental Health in Schools* programme, the extended schools policy and the *National Healthy Schools* programme:

- All schools are required to become 'extended schools' by 2010. To become an extended school, one of the criteria schools have to meet is to identify children and young people with behavioural, emotional and health needs or other difficulties, provide support for them, and refer them on to specialists where necessary.¹³⁸
- Schools in England are encouraged to work towards gaining *National Healthy Schools Status*. This requires them to go through a quality assurance process that assesses their performance in terms of four themes, including *Personal, Social and Health Education (PSHE)* and emotional health and well-being, including bullying.¹³⁹

Targeted Mental Health in Schools programme

In 2008, the Department of Health and the DCSF invested £60m in a joint three-year *Targeted Mental Health in Schools* programme.

In the first phase, pilots are being run with 25 local authorities and/or PCTs. Each authority or PCT is working with local primary and secondary schools to provide support for children and young people who are at risk or already experiencing mental health problems. Authorities and PCTs are being encouraged to work with a range of services, including

There is a shortage of therapists for children and young people, particularly in more remote areas.

Box 15: Improving Access to Psychological Therapies (IAPT) programme

The IAPT programme was introduced in 2007 to help PCTs improve treatment for people with depression and anxiety disorders by increasing the provision of psychological therapies.

Only a quarter of the six million people affected by these disorders in the UK receive treatment.¹ Psychological therapies are a recommended form of treatment for anxiety and depression, so, by improving access, the government hopes to reduce the number of people suffering from these conditions.

The aim is for IAPT to build a skilled workforce of therapists and increase access to treatment in locations that are close to people's homes, eg, GP surgeries, job centres and charities.

Although this investment is very welcome, its primary policy objective is to reduce sick pay and incapacity benefits, which means that the immediate focus is on adults. There is less emphasis on treating children and young people below working age, even though helping them could prevent depression and anxiety in adulthood. Only one of the IAPT pilot sites, in Bury, is concentrating on the provision of psychological therapies for children and young people. It is not clear to what extent this will be extended as part of the national roll-out of the programme.

NPC's research suggests that there is a shortage of therapists for children and young people, as well as adults, particularly in more remote areas of the country. Investing in children and young people's mental health charities that run training courses or provide professional development for the therapists they employ could therefore help to build the workforce and redress the balance.

Emotional well-being has been introduced as a formal part of the National Curriculum through *PSHE* and *SEAL*.

Promoting good mental health should underlie all work with children and young people.

charities, but it is too early to comment on progress. Evaluation of the pilots will then be used to inform the national roll-out of the programme in 2009–2011.¹⁴⁰

Targeted Mental Health in Schools represents a very welcome investment. However, until we know what the programme looks like on the ground, NPC cannot comment on the opportunities for charities and donors. There is a danger that the programme may be rolled out before clear objectives have been set. NPC's conversations with charities suggest that the criteria for allocating funding are not transparent and may vary from area to area.

It is difficult to gauge how much money each school is likely to receive in practice. As a ballpark estimate, if £60m were to be divided equally between the 22,300 state-maintained schools in England, NPC calculates that the average funding per school would be less than £3,000 over the three years.*

Curriculum

Emotional well-being has also been introduced as a formal part of the National Curriculum, through *Personal, Social and Health Education (PSHE)* and the *Social and Emotional Aspects of Learning (SEAL)* programme:

- *PSHE* has been a non-core part of the curriculum since 2000.[†] It covers topics including sex and relationship education, drug education, careers guidance, parenting and financial literacy. However, schools are given the freedom to tailor their programme to meet the age range and cultural background of their pupils.¹⁴³
- *SEAL* is a curriculum resource for primary and secondary schools, piloted in primary schools from 2003 and secondary schools from 2005. It is designed to improve social and communication skills, self-awareness, motivation, empathy and emotional well-being. *SEAL* aims to work with the whole school, for example through school assemblies, and provides materials for specific activities during and outside lesson time. By 2012 the government expects all primary schools and half of secondary schools in England to be implementing the *SEAL* programme.¹⁴⁴

These policies are important in providing schools with structure and incentives for promoting children's mental health. Although their effectiveness is difficult to gauge at this early stage, evaluations of *SEAL* and *PSHE* have shown some promising results. The overall conclusion seems to be that programmes

are successful where schools make them a priority, where they are given adequate time and resources, and where they are run by staff with specialist training. Well-run programmes can: improve teachers' confidence and skill in dealing with mental health problems; raise pupils' awareness of the issues; provide pupils with strategies for managing peer pressure; and improve their behaviour, teamwork, communication skills, motivation, concentration, and self-confidence.[‡]

However, the effectiveness of *PSHE* and *SEAL* programmes varies widely. Their funding is not ring-fenced, so schools have discretion over the status they give them and the resources that they commit to them. And if other priorities compete, these programmes may remain a 'bolt on', rather than becoming an integral part of the school culture.

The evaluations also identified a need for: improved assessment of outcomes; better understanding of pupils' needs and how programmes can be tailored to meet these; improved links with local authorities and other support services, including charities; and more specialist training for teachers and other school staff, who are unlikely to have a subject-specific qualification in *PSHE* or *SEAL*.¹⁴⁵⁻¹⁴⁸

NPC was also unclear about how the *Targeted Mental Health in Schools* programme might be linked to *SEAL* and *PSHE*.

NPC believes that there is a role for charities in helping schools to develop social and emotional support for pupils. Charities that do effective work in schools, from anti-bullying initiatives to therapy and after-school clubs, are discussed in Chapter 4. Given the many competing demands on school budgets, charities often struggle to recover their full costs from schools and local authorities, so donors can make a big difference by supporting their work.

Community

As children move into adolescence and adulthood, they spend less time in the supervised settings of home, school or college, and more time out and about in the community. The government can support this age group by developing the capacity of youth services, such as youth clubs and drop-in advice centres, to deal with mental health problems. Charities such as YIACS are particularly valuable for this age group. They also provide help and advice on a range of other practical issues like homelessness or unemployment, which might be related to young people's mental health problems. These organisations are vital in improving access to help for 'hard to reach' young people.

* Estimate based on DCSF data about schools and pupils in England in January 2007.¹⁴¹

[†] It is now known as *Personal and Social Education (PSE)* in Wales, where a revised curriculum was published in September 2008.¹⁴²

[‡] Although the evaluations have found it difficult to control for other factors that might influence these changes.



Photograph supplied by istockphoto.com

In many cases, the young people who are most in need of support are not in school or college at all. Their mental health problems may have caused disruptive behaviour that led them to be excluded from mainstream education. These groups of young people may be found in pupil referral units (PRUs) or in youth offending institutions. It is therefore valuable for staff in these organisations to be trained to identify and manage mental health problems. For further information on charities that work with these groups, readers can refer to NPC's report on truancy and exclusion, *School's out*, and forthcoming research on youth offending.

What is the policy in Scotland?

Recent policies in Scotland have similarly emphasised that mental health should be the responsibility of everyone working with children and young people. The *Scottish Needs Assessment Programme (SNAP) Report on Child and Adolescent Mental Health*, published in 2003, discussed the importance of addressing 'the whole continuum of mental health', from preventing mental illness to caring for individuals with severe mental health disorders. It stressed that a focus on promoting *good* mental health and supporting recovery should underlie all work with children and young people, including those who are already experiencing problems.¹⁴⁹

A framework for implementing this approach was provided in *The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care* (2005), which set out principles and priorities for improving mental health in Scotland up to 2015.¹⁵⁰ This framework was accompanied by:

- *Delivering for Mental Health* (2006), a policy document which defined specific targets, including: a named mental health link person available to every school, and basic mental health training for all people working with looked-after children and young people by 2008; a reduction in the number of admissions of children and young people to adult psychiatric beds by 50% by 2009; and increased access to evidence-based psychological therapies for all age groups by 2010.¹⁵¹
- *HeadsUpScotland*, a project run from the Scottish Development Centre for Mental Health, was set up to: support the local implementation of the SNAP recommendations; involve children, young people, parents and carers in policy and service development; and develop the workforce. Resources it produced include *HandsOnScotland*, an online toolkit designed to help frontline workers think about how to support children and young people with a wide range of emotional and

The Scottish Government aims to halve the number of young people admitted to adult psychiatric beds by 2009.

behavioural problems. This can be viewed at: www.handsonscotland.co.uk. The project is coming to an end in Autumn 2008.

Better coordination and collaboration between health, education and social care services is a wider objective of the Scottish Government, as enshrined in its *Getting it right for every child* programme, which is equivalent to the *Every child matters* policy in England.¹⁵²

The promotion of emotional well-being is also an objective of Scottish education policy, highlighted in the *Curriculum for Excellence* and recent legislation on health promotion in schools. School-based mental health promotion initiatives are being run by Learning & Teaching Scotland, in partnership with NHS Scotland.

Future policy

The Scottish Government is currently developing its mental health policy for 2008–2011 (this had not been published at the time of writing). Experts suggested that there is likely to be a focus on addressing health inequalities. Children and young people's mental health will continue to be a priority, but which particular elements will be emphasised is unclear. The government's anti-stigma campaign and *Choose Life* strategy for preventing suicide are set to continue. The government will also provide two years of further funding for Young Scotland in Mind, a forum for charities working on children and young people's mental health (see Chapter 4).

Other interesting initiatives include: the development of new national indicators that local authorities and the NHS can use to measure levels of emotional well-being and mental illness; and the development of a matrix for commissioners and practitioners in CAMHS comparing the effectiveness of different psychological therapies. A new early years strategy is also due to be published, which may have implications for policy relating to parenting and infant mental health.^{153, 154}

Funding

In Scotland, funding for CAMHS is not ring-fenced: budgets for mental health overall are devolved to the NHS and local authorities, which allocate the funding to different age groups. In 2006/2007, the Scottish government allocated £651m to the NHS, and £73m to local authorities, for mental health.¹⁵⁴ Establishing the levels of funding available for promotion and prevention is more complicated, as this is usually integrated within broader programmes to support children and young people.

What is the policy in Wales?

The Welsh Assembly Government has also defined mental health as a priority. In September 2001, it published a ten-year CAMHS strategy, entitled *Everybody's Business*.¹⁵⁵ However, there are still widespread concerns over the quality and reach of specialist CAMHS in Wales. These are being addressed by a review that is being conducted by the Welsh Audit Office and the Health Inspectorate Wales.^{156, 157} The review is due for publication in January 2009 and may lead to funding changes. In the meantime, the Shadow Health Minister for Wales has raised concerns that the budget for CAMHS was reduced by £1m in 2006/2007.^{*158, 159}

Broader government initiatives that are relevant to children and young people's emotional well-being include the launch of a new strategy in 2008 to develop counselling services in all Welsh secondary schools.^{†142} The *Children First* programme and *Cymorth* (the Children and Youth Support Fund) also support vulnerable children and families, although they are not specifically targeted at mental health.¹⁶⁰

Further information about policy or funding was not available at the time of writing.

What are the gaps?

NPC has identified four main priorities for the development of government services, based on the CAMHS Review and other reports by government and charities. Much of the evidence about these gaps comes from England, but NPC's discussions with experts suggest that many of them are also relevant to the situation in Wales and Scotland.

1. Improving accessibility of services

- Only **one in four children** aged 5 to 15 with a diagnosed mental health disorder was accessing **a specialist mental health service** over a three year period, according to a report published in 2006. This may have improved since then, but not in all areas.¹¹
- **Waiting lists for specialist CAMHS can be very long** for children and young people who are not in crisis. Although the situation is improving, a report in 2006 found that one in six children and young people had been waiting for over six months for an appointment with specialist CAMHS (at Tiers 2–3).^{†11}
- Sometimes the drive to reduce waiting lists has **pushed people into the wrong service**. This includes adolescents being put into paediatric wards or adult wards.¹¹

Only one in four children with a diagnosed mental health disorder is receiving specialist treatment.

* The Shadow Health Minister for Wales, Jonathan Morgan, has called for a reassessment of the funding allocation for mental health services.

† Research in 2005 suggested that around half of Welsh schools had existing counselling provision.

‡ At Tiers 2 and 3, 32% of children and young people had been waiting for up to three months; 15% for between three and six months; and 18% for over six months.

- Lack of local provision means that some children and young people end up being **sent to psychiatric units that are far from home.*** This can be alienating and makes it more difficult for family and friends to visit.
- **Treatment is not always flexible or accessible.** Children and young people may not know how to seek help or are intimidated by the prospect of going to a GP. They may not be able to access support if it is only offered during school hours or may be reliant on a parent or carer to take them to a specialist. The situation has improved significantly, but 18% of NHS trusts in England were not providing 24/7 on-call services with a specialist CAMHS response in 2007.^{125, 161}
- **Access to talking therapies is very limited.** A national survey in 2006 found that 93% of GPs had said they had been forced to prescribe antidepressants for adults rather than talking therapies due to the unavailability of the latter. In 2008, a freedom of information request found that across 33 PCTs, the average waiting time for Cognitive Behavioural Therapy (CBT) was seven months. The waiting time for counselling and psychotherapy was even longer—over three years in the case of one PCT. NPC could not find equivalent statistics specifically for children and young people.^{†162}

2. Providing appropriate services and support for transition

- There is a **lack of targeted support** for young people, particularly for **16–25 year olds**.
- **Transitions can be difficult.** Young people moving between CAMHS and AMHS need support and, where possible, continuity of treatment, so they do not feel abandoned. Local charities can help with this by providing support workers who act as advocates.
- **Emergency services can be alienating** for children and young people who are at their most vulnerable. More training for A&E staff in mental health issues, such as self-harm, would help them provide appropriate care and support for children and young people.³

3. Improving training and partnership

- **Better training and support for Tier 1 professionals**, such as teachers, nurses and GPs, could improve their ability to identify and manage mental health problems.¹⁶³
- The **links between specialist CAMHS, schools and other non-specialist agencies could improve.** In some local

Box 16: Kay's story

Kay's account of her experience with CAMHS illustrates many of the challenges that children and families face.

'Hello, my name is Kay, I am 12 years old. I like my Mum and my cat. I have been diagnosed with a number of things which over time have changed. I have been diagnosed with the following: psychosis, schizophrenia, sleeping disorders, severe depression, Obsessive Compulsive Disorder, eating disorders, hallucinations, post traumatic stress disorders, I was told once by an agency nurse that I act as if I'm possessed! The amount of times they change it, it wouldn't surprise me if they diagnosed me with Gulf War Syndrome! In my life of 12 years, I have been on: Risperidol, Loreazepam, Citalopram, Fluoxetine, Olanzapine, Melatonin, Diazepam, ARYM-Haloperidol.'

What Kay's parents thought: *'I felt that the continuity of care was poor. Being passed between different social workers, counsellors, psychiatrists and therapists is very debilitating and depressing both as a parent or a child. I found it hard enough coming to terms with the nature of my child's condition, let alone constantly relaying the story and having a different slant on it each time. You and your child begin to move backwards, you get so far with one person but then you have to start it all over again. This could be improved if an aid worker was assigned to your case and followed it to the end.'*

areas professionals work together well, but in many this is not the case. It seems that there are limited incentives for joint working at a local level, and different professionals often have different approaches to managing mental health problems. Within the therapeutic community there can also be divisions between different ideological schools, and competition for very limited funds. For small charities, a lack of resources and internal infrastructure is a barrier to developing better links with other organisations.

- **Poor coordination** leads to children and young people being passed around between different professionals and mental health services. This can be alienating and bewildering (see Box 16). Children and young people would prefer to be seen as a whole person rather than as a clinical diagnosis.
- NPC is aware that there are **power imbalances between different professionals** in this sector. Authority is often vested in psychiatrists, which leaves some professionals and specialists, particularly those from a non-clinical background, feeling marginalised in decision-making. It is important to ensure that other groups are equally well represented, particularly as CAMHS moves towards a more comprehensive approach, encompassing promotion and prevention. One way of encouraging a change in culture would be to offer training and leadership opportunities for professionals from other backgrounds.

Young people moving between CAMHS and AMHS need support.

* NPC could not find any central statistics about the number of children and young people sent for treatment outside their area.

† This research is primarily about adults' access to talking therapies.

Charities are well-placed to involve children and young people in the development of mental health services.

- Commissioning of children and young people's **mental health services** needs to be **integrated** with the wider commissioning of **children's services**. This includes services for particular groups at risk of developing mental health problems, and adult mental health services. Good communication between commissioners should help to identify common objectives and prevent protectionism over competing budgets.¹⁶⁴
- Improving the knowledge of commissioners from a healthcare background about **effective education and social care approaches** to improving mental health would also be beneficial.

4. Responding to children and young people's preferences

- All too often **children and young people's views are not sought** or acted upon when services are developed and evaluated. Consulting young people would help to ensure that services are more accessible and meet their needs. This in turn would encourage them to use the services.
- Services need to take into account **young people's priorities**, and meet their **practical** as well as **emotional** needs. For example, issues associated with homelessness or foster care may contribute to mental health problems, so dealing with one in isolation from the other may not be effective.

The problems outlined above may be magnified for children and young people from black and minority ethnic (BME) groups. Accessing and navigating mental health services can be particularly difficult for individuals who are new to an area and are not native English speakers,

so it is important that services are offered in different languages. There is also greater stigma attached to going to mental health services among some BME groups, and family dynamics may be different. For example, as one young person commented: *'Asian parents don't understand eating disorders. So white professionals need to be aware of this and the fact that young Asians can't always talk to their parents in the same way that young white people might be able to.'*¹¹⁵

Messages for charities and donors

Government mental health services are improving and the new emphasis on promoting emotional well-being through work with families and schools is very welcome. There is a great deal more that could be done, and an increase in government funding for CAMHS would certainly help.

Charities working in this sector have also suffered from a lack of resources, and this has, in turn, limited their ability to campaign for policy change. NPC was struck by the contrast with other sectors, such as disabled children or adult mental health, where greater resources have helped charities to develop a stronger campaigning voice (see Box 17).

At a structural level, government's efforts would be helped by strengthening partnerships between professionals. Improving the skills of frontline staff through training in identifying and managing mental health problems from an early age would also be beneficial. Charities can contribute to this process. Although there is a danger that increasing the identification of mental health problems could put even more pressure on specialist CAMHS, improving the skills of frontline staff should mean that fewer children and young people needed to be referred on to specialist CAMHS.

Charities are well-placed to involve children and young people in the development of mental health services and the formulation of policy. In many cases they can also offer more informal, flexible and friendly support for children and young people than state institutions, and help take the pressure off CAMHS and schools, as we will see in the next chapter.

Donors who are interested in improving basic provision have a wide range of options which can make a difference. They could fund a charity that: contributes to policy development; provides training and professional development across the statutory and voluntary sectors; or helps to make up the shortfall in government services.

The challenges and options for donors will be discussed in more detail in Chapters 5 and 6.

Box 17: Campaigning for change: £340m for disabled children

Disabled children charities have been successful in getting the government to move disabled children up the political agenda and follow promises with concrete policy change and cash.

In May 2007 the government announced the results of a Comprehensive Spending Review (CSR), which pledged £340m to improve services for disabled children and their families, spread over the three years from 2008–2011. The CSR was in response to a long-running campaign—*Every Disabled Child Matters*—which is coordinated by a consortium of four charities: Council for Disabled Children, Contact a Family, Mencap, and Special Education Consortium.

This is a good example of the difference that can be made by an ambitious donor funding a coordinated campaigning effort. The consortium was part-funded by the True Colours Trust, via grants to the Council for Disabled Children and Contact a Family. The precise impact of the True Colours grants on the campaign is impossible to gauge, but it certainly helped the charities to consolidate early progress, provided evidence to support the campaign's case and, ultimately, win major resources for the sector.

What are charities doing?

Charities play a vital role in improving the mental health of children and young people. They help to fill gaps in government services by picking up hard-to-reach children and young people, and giving them the kind of support that they need. They also raise awareness of mental health issues and involve young people in improving the way services are delivered.

However, the charity sector for children and young people's mental health is thin and under-resourced in comparison to the scale of the problem. The national charities are relatively small and the rest of the sector is fragmented between charities focused on different areas or issues. The implication of this is that the campaigning voice for child mental health issues is weak relative to other sectors, and achieving large-scale change is difficult. With additional funding there is a lot more that charities could do.

This chapter discusses the role of charities, the structure of the sector, and what different types of charities are doing.

What is the role of charities?

Improving children and young people's mental health is about more than treating diagnosed conditions. While the NHS and specialist CAMHS are responsible for clinical treatment, charities are able to contribute by: providing social support; working to prevent mental ill health and promote good health; and by helping children and young people get the treatment they need.

Charities provide many of the qualities that those experiencing mental health problems want: accessibility; time; choice; non-stigmatising support; and approaches that help the whole person rather than just treat a condition. They are also at the forefront in:

- providing accessible information and support for 'hard-to-reach' young people;
- offering treatment for 16–25 year olds that meets the specific needs of this age group and addresses their practical, social and health problems; and
- involving young people in improving services.

What does the charity sector look like?

Relative to other sectors that NPC has researched (including the adult mental health sector), the charity sector for children and young people's mental health is very small—both in the number and size of charities. It is also extremely under-resourced. The leading national charity in the sector, **YoungMinds**, has an income of just £1.9m. By contrast, the comparable adult mental health charity, **Mind**, has an income of £16m, and there are other large adult charities such as **Rethink** and **Mental Health Matters**. The scale of this difference cannot be explained by relative levels of need; funding for the children's mental health sector needs to grow considerably in order to meet requirements.

It is also a fragmented sector. Many charities NPC spoke to do not have a sense of belonging to a clearly defined 'child mental health sector', or of who the other charities in the field might be. Indeed many did not identify themselves as 'child mental health charities' at all. For some this is because they are not solely focused on children; for others it is because mental health is not the explicit focus of their work. Many work with groups of vulnerable children for whom mental health is an underlying issue. The sector is also fragmented because of professional divisions and ideological differences, for example: between medical and social approaches, CBT and psychoanalysis, or voluntary and public sector bodies.

Ultimately, the poorly defined and fragmented nature of the sector is a reflection of the fact that 'mental health' overlaps with so many other social issues—from child abuse to bullying, truancy to crime—and covers an enormous range of conditions, approaches and interventions—from promoting good health in the general population to treating severe psychiatric illnesses in a small minority. For donors this means that solutions to mental health issues, especially prevention, can also be found outside the specialist mental health sector.

Table 6 shows the main groups of charities working to improve children and young people's mental health.

The charity sector for children and young people's mental health is very small—both in the number and size of charities.

Table 6: The structure of the sector

Type of charity	Examples and size (approx.)	Services provided
<p>National mental health charities</p> <p>YoungMinds is the only mental health charity specifically addressing the needs of children and young people throughout the UK.</p> <p>The Anna Freud Centre provides clinical services for children and families in London, and its research and training have national influence.</p> <p>Youth Access is a national umbrella body for YIACS (see below).</p> <p>Adult mental health charities such as the Mental Health Foundation, Mind, Rethink, the Scottish Association for Mental Health, Penumbra and Samaritans have strands of work relating to young people, but are predominantly focused on adults.*</p>	<p>YoungMinds £1.9m</p> <p>Anna Freud Centre £3m</p> <p>Youth Access £800,000</p> <p>Adult charities are much bigger (£5–20m) but their work with children is limited</p>	<ul style="list-style-type: none"> • Information • Training • Research • Campaigning • Participation • Helplines • Consultancy
<p>Local Youth Information, Advice, Counselling and Support Services (YIACS)</p> <p>Youth Information Advice Counselling and Support Services, known as YIACS, are usually community-based drop-in centres for 11–25 year olds. There are approximately 350 in England, and a total of 470 across the UK. Many are based on youth work, though a few have a more clinical approach (eg, The Brandon Centre). Around 60% are linked to specialist CAMHS.¹⁶⁵</p>	<p>The Brandon Centre, 42nd Street, The Marketplace, MAP, The Corner</p> <p><£1m</p> <p>Total income of YIACS is £100m–200m</p>	<ul style="list-style-type: none"> • Counselling and therapy • Group work • Social activities • Information and advice • Sexual health clinics
<p>Condition-specific charities</p> <p>Tackle a range of conditions including eating disorders, obsessive compulsive disorder (OCD), bedwetting, phobias and hyperactivity. Though most are small, these charities tend to have a national remit, work with all age groups, and have a wide range of services. They are often founded and run by former sufferers.</p>	<p>beat, OCD Action, Addis, Anxiety UK, ERIC</p> <p><£1m</p>	<ul style="list-style-type: none"> • Helplines • Information and advice • Training and conferences • Self-help groups • Campaigning
<p>Charities working with families and specific groups</p> <p>Work with groups of vulnerable children such as asylum seekers, or children of parents with mental health problems. Tackle causes and effects of mental ill health. Often employ specialist mental health workers, and may work with parents and families as well as children.</p>	<p>Family Action £20m</p> <p>Medical Foundation for the Care of Victims of Torture £8m</p>	<ul style="list-style-type: none"> • Therapy • Practical support • Information and advice
<p>School-based charities</p> <p>Work on a range of issues, for example bullying, truancy and exclusion, and emotional literacy. Charities take either a 'targeted' approach to identify and support those at risk of mental health problems, or a 'whole-school' approach to improve well-being and the school environment.</p>	<p>The Place2Be, Antidote, Beatbullying</p> <p><£6m</p>	<ul style="list-style-type: none"> • Counselling and therapy • Emotional literacy • Anti-bullying support • Support for parents • Training
<p>National children and youth charities</p> <p>Focus on vulnerable children generally, and work on specific issues such as child abuse, young refugees, youth offending, and children in care. Mental health is often an underlying issue, and increasingly these charities have designated strands of mental health activity. They work with large numbers of children throughout the UK and deliver public services, eg, through <i>Sure Start</i> children's centres, social work, and adoption services.</p>	<p>Barnardo's, Action for Children (formerly NCH), NSPCC >£100m</p> <p>Prince's Trust £45m</p> <p>Coram £7m</p>	<p>Working with large numbers of vulnerable children and young people in a variety of ways.</p> <p>ChildLine (run by the NSPCC, except in Scotland) offers 24/7 confidential emotional support for children and young people.</p>

* It is difficult to identify how much of their expenditure is allocated to children and young people's mental health without carrying out detailed analysis. As an example, just over 10% of Penumbra's expenditure (£784,000) was dedicated to young people's services in 2006. We suspect that this may be higher than for many other adult mental health charities.

History of the sector

The child mental health sector is growing, but for a long time it has received little recognition or investment. Mental health problems were traditionally seen as the preserve of medical specialists and not the business of charities—a view that persists in some areas today.

It is only recently that a broader understanding of mental health has emerged. Since the mid-1990s, child mental health has moved beyond the province of psychiatry. The ethos that mental health is ‘everybody’s business’ has led to an increased awareness of the role that charities can play in promoting good mental health and preventing and treating mental health problems.

But it remains a relatively new sector. To make another comparison with adult mental health, YoungMinds was founded as recently as 1989, whereas Mind was set up in 1946.

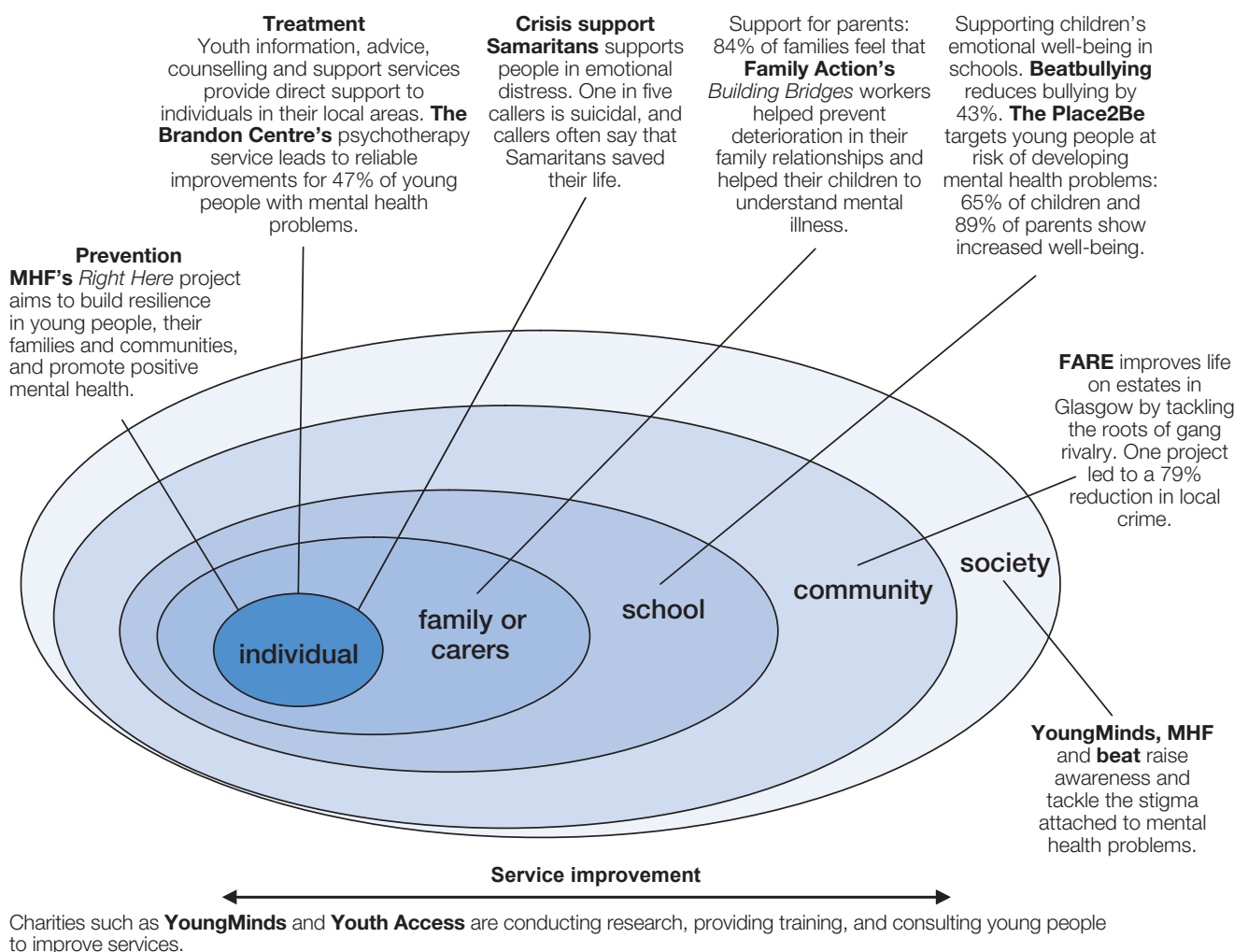
What are charities doing?

Charities are involved in a wide range of activities, from providing direct treatment to lobbying for changes to services. They provide many of the qualities that those experiencing mental health

problems want from services. They also tend to provide services in places where young people feel comfortable: schools, youth clubs, high street drop-ins, and online. Figure 3 below shows the different places where charities can intervene to improve children and young people’s mental health. It also gives examples of charities working in these spaces and the results that they get. This chapter discusses charities in four main areas:

1. **Providing treatment and support** for individuals with mental health problems (this is where the bulk of activity is focused).
2. **Tackling risk factors**, often using a range of approaches not necessarily ‘branded’ as mental health work, including work with parents, anti-bullying or ‘emotional literacy’ work in schools, and programmes that combat domestic violence or child abuse.
3. **Changing society**, by campaigning and raising awareness of mental health issues, to tackle stigma and lobby for policy change (the sector is limited here).
4. **Improving services and the infrastructure of the sector**, through research, training, and involving young people.

Figure 3: How are charities improving children and young people’s mental health?



1. Providing treatment and support

Many of those who need treatment for mental health problems are not getting it. This may be for a variety of reasons: their condition has not been identified or is not beyond a certain threshold of severity; there are no services available; or they do not want to see a professional in a clinical setting. Supporting these children and young people often falls to charities who provide a range of services (see Figure 4). Specifically, they:

- provide information (to help a young person or parent understand a condition);
- link young people or families to specialist services;
- act as advocates for young people already in, or in need of, treatment;
- provide direct treatment such as counselling, psychotherapy or group work;
- offer indirect support (through self-help groups);
- provide support during crises (for example, through 24-hour helplines); and
- offer advice and support on relevant social welfare issues such as housing, employment or sexual health.

The bulk of this support is provided through: local counselling services ('YIACS'); small, condition-specific charities; and charities that work with particular groups, such as abused children or asylum seekers. Most of these charities would not necessarily describe what they do as 'treatment', and very few work in inpatient units (Tier 4 CAMHS). However, many provide services at Tiers 1–3 and work with young people who have very complex problems.

Figure 4: Charities identifying and treating mental health problems



Youth Information Advice Counselling and Support Services (YIACS)

YIACS are drop-in centres for 11 to 25 year olds. They are usually based in city or town centres and have a 'shop front' where young people can walk in from the street and sign up for counselling or group work. They also provide information and advice on issues such as housing, sexual health, and employment.

There are around 470 services of this kind throughout the UK, and they are, collectively, the biggest provider of youth counselling services (although not every YIACS offers counselling). Most work with hundreds, and some with thousands, of young people on an annual basis, and NPC estimates that collectively YIACS see approximately 44,000 young people a week in England.

NPC's research suggests that YIACS are of critical importance to the children and young people's mental health sector. Around 60% are linked to specialist CAMHS, who refer young people on to them.¹⁶⁵ YIACS provide treatment for young people who would not otherwise access support. This may be because they are too old for CAMHS, waiting lists for specialist CAMHS are too long, or their condition is not above a certain threshold of severity. As one CAMHS psychologist told NPC: *'If it wasn't for our local YIACS service, we would be swamped'*.

YIACS also address practical and social issues such as sexual health and relationship problems that may be affecting young people's mental health. Attempting to improve mental health without addressing these other issues is unlikely to be successful, but to get this range of support from the statutory sector a young person would typically have to access two or three different services. YIACS provide a 'one-stop shop' and young people like being able to access a range of services in this way.

Attending a clinical service can be an alienating experience, and feedback from young people shows that they value the informal and confidential environment of YIACS. Though YIACS differ in approach—some are based more in youth work, such as **42nd Street** (Box 18), and others are more clinical, such as **The Brandon Centre** (Box 19)—all have a friendly, open atmosphere. Young people feel that there is less stigma attached to accessing a YIACS service because, for all their friends and family know, they could be dropping in to collect condoms or get job advice, rather than to see a therapist.

YIACS are particularly important for 16 to 25 year olds, many of whom fall beyond the remit of CAMHS. These young people face specific issues associated with the transition from adolescence to adulthood, which adult mental health services are not well equipped to address. The expertise of YIACS services with young people in this age bracket is therefore extremely valuable.

YIACS also give young people a chance to meet other people who are facing similar problems, helping to reduce their sense of isolation. **Croydon Drop In** is a YIACS that has a youth participation group for 15–24 year olds. One young person described what it meant to her: *‘Being a member of the group is a very important thing to me because whenever I go to the group I feel very comfortable and more relaxed... Before, I was the one who was not feeling comfortable when I’m in the group, because of trust and I was not sure whether people in the group will understand and accept me. I don’t feel withdrawn anymore because I have met people who have had similar experiences to me.’*

Many YIACS have developed tailored services in response to specific local needs. As well as counselling and information, **Mancroft Advice Project (MAP)** provides advice on sexual health to address the problems of high teenage pregnancy around Norwich. **Faces in Focus** in south London has developed expertise in supporting young men who have problems with anger and gang-related issues. **The Brandon Centre** has introduced parent-training and multisystemic therapy programmes in response to the high levels of conduct disorders and antisocial behaviour it sees.

Although they form a vital part of local mental health provision, most YIACS are small, under-resourced charities. Their income ranges from approximately £50,000 to £1.2m per year, with few YIACS at the upper end of this scale. They tend to rely on a patchwork of local authority or PCT funding streams and are vulnerable to sudden funding cuts.

Donors can therefore make a big difference to local mental health provision by funding a YIACS service, although this is likely to involve a level of risk. Chapter 5 will discuss the challenges facing YIACS in more detail and Chapter 6 will include guidelines for donors on what to look for in a good YIACS service.

Helplines and websites

Understanding the mental health problems they experience reduces the distress that many sufferers and families feel. Charities provide easily accessible information in non-medical language, which helps sufferers, families and professionals to understand problems and seek help.

Information and advice

Online and helpline services are particularly popular with young people. A recent survey found that 37% of 12–18 year olds would turn to the internet first for mental health advice.¹² Charities enable sufferers to make initial contact in confidence through a helpline or website, then move into a more supportive situation through a self-help group, online group or by being linked to a local service. This helps to relieve their distress and isolation, provides them with information about the condition and services available, and encourages them to seek specialist help if they need it.

When parents discover that their child has a mental health problem, they often experience considerable anxiety, and lack knowledge and confidence about how to help them.

YoungMinds has been running a parent information helpline for 15 years. Parents who are worried about their child’s behaviour can call the helpline and speak to a team who give support and reassurance, and can provide details of local or national support services. If the call is more serious, parents can request a call-back from a specialist mental health professional. Callers say that speaking to someone who knows about mental health problems reassures them and helps them to understand the different options open to them.

“Without the call to YoungMinds I don’t think our family could have held together. My son’s illness was pulling us all apart.”



Photograph supplied by Kristian Buus

Charities dedicated to specific mental health disorders play a valuable role in providing information and support.

Table 7: Condition-specific charities

Condition	Charities
Anxiety disorders and phobias	Anxiety UK
Bedwetting	ERIC
Depression	Depression Alliance; Charlie Waller Memorial Trust
Early onset psychosis	Rethink; the Zone
Eating disorders	beat
Hyperkinetic disorders	Addiss; Hyperactive Children's Support Group; Studio ADHD Centre; ADHD UK Alliance
Obsessive compulsive disorder (OCD)	OCD Action; OCD UK
Post-traumatic stress disorder	Northern Ireland Centre for Trauma and Transformation; Medical Foundation for the Care of Victims of Torture
Self-harm	See Box 20
Suicide	Samaritans; Papyrus

Charities dedicated to specific mental health disorders also play a valuable role in providing information and support. Not all are specific to children and young people. However, charities focused on conditions such as eating disorders, ADHD, enuresis (bedwetting) and self-harm will primarily work with children, younger people and their families, where the need is greater. Table 7 gives examples of charities working with specific conditions or mental health needs (it is not an exhaustive list). Some are larger charities that have specialist strands working with certain conditions.

Mental health services are often fragmented and patchy, and many families struggle to find advice. Charities play an important role in linking individuals and families to treatment. **Get Connected** is a charity that runs a free, confidential helpline, via telephone, email and webchat. It provides young people with support and information about who they should contact for help on issues ranging from finding somewhere safe to stay for the night, to getting help for a specific mental health problem, or just being listened to. **beat**, the national charity for eating disorders, has a helpline and *Help Finder* directory, which provide information for sufferers and families—on NHS and private treatment

centres, private counsellors and voluntary organisations in their area.

Charities and donors who are interested in developing helplines should refer to two organisations. Charities can get specialist advice and training about running non-profit helplines from the **Telephone Helplines Association (THA)**. The THA has over 500 members, including Samaritans and ChildLine, and holds information about 1,100 services across the UK and internationally. Linked to the THA is the **Mental Health Helplines Partnership (mhhp)**, a consortium of mental health helplines in England funded by the Department of Health. The mhhp developed the *Mental Health Helpline Worker Training Programme* with the THA, and also the *Mental Health Helplines Quality Standard*, an accreditation scheme that donors may find helpful in identifying effective services.

Self-help groups

Group work can reduce the isolation that many young people experience, and motivate them to seek professional help. For example, **beat** and **OCD Action** coordinate and support self-help groups throughout the country. Self-help groups are also a valuable source of ongoing support after young people leave services. The period following discharge can be difficult; people in recovery need support so that they do not relapse. Self-help groups have been recognised by NICE as an effective part of treatment plans for eating disorders.¹⁰⁵

However, it is difficult for charities to regulate the quality of self-help groups and, if misused, they can have potentially negative consequences for sufferers' health. In order to mitigate these risks, charities should train volunteers and monitor activities carefully.

Box 18: Improving mental health in Manchester

42nd Street is a youth service based in Manchester. It provides counselling, advice, information and support for young people aged 14–25. It has dedicated services for black young people and LGBTQ (lesbian, gay, bisexual, transsexual, questioning) youth, and an arts-based project for disabled young people. Group work and creative activities are also on offer, and the charity finds that they are effective in engaging young people who might initially be reluctant to go to a counsellor.

Over 700 young people a year are referred to 42nd Street for specialist support. It has excellent links with its local CAMHS services, and young people really value its friendly approach: *'It's a safe and secure place, in which the workers treat you with a lot of respect and don't judge you. This therefore helps you to open up and feel safe to explore feelings.'*

Box 19: Clinical services in the community

The Brandon Centre, a charity in north London, offers an excellent example of how a YIACS service can develop innovative programmes and use its results to inform national policy.

Over 2,000 young people between the ages of 12 and 25 access support for their mental and sexual health issues through The Brandon Centre every year. Based in welcoming and non-institutional premises in the heart of the local community, young people feel comfortable dropping in, whether for therapy, contraception, sexual health screening or information and advice. It has good links with the local CAMHS service, which often refers young people to the Centre, but 40% of the young people receiving counselling and psychotherapy there referred themselves for treatment, and a further 10% were referred by their parents.

The Centre has a rigorous approach to measuring its results, using well-validated clinical scales and feedback from young people. It makes impressive use of this data to inform the development of its services. For example, monitoring showed that 40% of the young people receiving counselling and psychotherapy at the Centre have violent and offending behaviour or other conduct problems. These young people are most likely to drop out of therapy. It therefore introduced two other programmes that have had promising results with disruptive teenagers: parent-training sessions offering practical support and guidance for parents on how to manage their child's behaviour, and multisystemic therapy (MST), which works closely with families of persistent young offenders to change their destructive behaviour patterns. The Centre was one of the first organisations in the UK to introduce MST. Sponsored by the Department of Health, it is conducting a randomised controlled trial to test its effectiveness, which is helping to inform the roll-out of MST elsewhere in the country.

The economic returns on a charity like The Brandon Centre are excellent. In 2007 its psychotherapy service was used by 268 young people and cost £226,000. Nearly half—47%—showed reliable improvements to their mental health. This improvement means that the young people are able to function better. For instance, a teenager who was truanting because of anxiety and depression related to family problems might now have an improved attendance record. So the cost per person showing improvement is only around £1,800. This is a tiny sum compared to the costs this treatment prevents. NPC estimates that stopping a teenager from being excluded saves £20,000 in costs to the education system alone. There is, therefore, at least a ten-fold return to investing in The Brandon Centre.

Box 20: Charities supporting young people who self-harm

NPC has come across a wide range of charities working with young people who self-harm. However, there is no charity taking an obvious lead on the issue. Many youth counselling services have developed experience in this area, but there is little agreement about 'what works'. A key message from young people is that they want a range of options, and that a 'one size fits all' approach will not work. It is increasingly being suggested that interventions aimed at stopping young people from self-harming may end up being counterproductive. Instead, support should address the underlying issues and focus on harm minimisation and encouraging other more positive methods of coping.

Until recently, self-harm projects were well-funded by the Camelot Foundation and the *Choose Life* strategy in Scotland. However, the Camelot funding has now come to an end and the *Choose Life* funding is no longer designated for this purpose. There is growing awareness of what self-harm is, thanks in large part to some of the charities they funded. Charities doing interesting work around self-harm are listed below.

- **42nd Street** was one of the first charities to argue that dealing with self-harm should not be all about 'containment' (ie, stopping it). This was initially a controversial position, but one that is increasingly accepted. It is also developing an online 'centre of excellence' on self-harm. In addition, 42nd Street provides suicide/self-harm training to other organisations.
- **The Amber Project** in Cardiff runs workshops and counselling for 14–25 year olds who self-harm. Two thirds of young people said that their levels of self-harm had decreased since they had joined the project. The project also uses 'forum theatre'. In one case young people made a piece of theatre about attending A&E after self-harming, which they then performed at a training day for A&E nurses. This helped the young people gain confidence and make friends, whilst also improving future experiences at A&E for people who self-harm.
- **Bristol Crisis Service for Women** runs a national helpline and offers specific training around self-harm for a variety of professionals. It also publishes research and is currently doing joint research with the Norah Fry Centre at Bristol University around self-harm and learning disabilities.
- **The Mental Health Foundation** undertook a national inquiry into self-harm in 2004–2006. Its report, *Truth Hurts*, is important evidence for the sector. It has helped to establish the prevalence of self-harm (one in fifteen), and increased our understanding of what young people want from services.
- **The National Self-Harm Network** is a 'survivor-led' organisation, which raises awareness of self-harm. It runs an online support forum serving over 2,000 members. This forum is administered and moderated by trained volunteers to maintain a safe environment where members can express their feelings and receive support from their peers.
- **Penumbra** has six projects across Scotland which aim to tackle self-harm issues for young people. One of these, *Positive Choices*, uses one-to-one sessions, drop-ins and social groups to give young people basic coping strategies to promote resilience to self-harm. Young people report reductions in self-harming behaviour.

‘It’s important that young people are able to have a part of their life that focuses on them as a person rather than just what is wrong with them.’

Crisis support

Many young people in emotional distress do not know where to turn. They may feel embarrassed or ashamed by a difficulty; they may be unsure who to ask or where to go for help; they may not have family or friends they can talk to. Suffering in silence can lead to loneliness and isolation, and, in extreme cases, to despair, depression, self-harm and suicidal thoughts. The need is particularly acute during the night when it is difficult to find help or access other services. Although around 25,000 young people are admitted to hospital every year after harming themselves,² there is no national charity that is taking a lead on self-harm (see Box 20).

Samaritans provides confidential support for people who are experiencing emotional distress or despair, including suicidal feelings. It offers help 24 hours a day via telephone, email, SMS messaging, face-to-face visits and written correspondence. It receives over five million contacts per year, and one in five callers is suicidal.

Although available for anyone, Samaritans is increasingly being used by young people, especially its email and text-messaging services. In a recent survey of its users, 40% of respondents were aged 15–25 and 7% were under 15.* Email and text-messaging services have helped Samaritans to reach a younger audience who are high users of new technology. Of these callers, many have more acute needs: whereas 20% of callers to the helpline are suicidal, 30% of email and 35% of text-message users are suicidal. Samaritans’ support helps young people to cope at times of distress and crisis, and in many cases helps them decide not to commit suicide.

ChildLine, a free and confidential helpline run by the NSPCC (except in Scotland, where it is run by Children 1st) also offers help 24 hours a day. Many children who suffer abuse are too scared to report it and feel that they have nowhere to turn. Three quarters of sexually abused children tell no-one when the abuse occurs, and even when they do, they have to tell an average of three people before anything is done.^{166, 167}

ChildLine provides advice and counselling either as a one-off or over an extended period of time. There is also a related online service, **there4me**, which provides information, advice and support aimed at 12–16 year olds. It has an agony aunt feature and a one-on-one chat facility that enables young people to speak with skilled advisers. An evaluation found that two-thirds of children said they were better able to deal with

their problems after contacting there4me. One young person commented: ‘I was so low at points throughout the abuse that I really wanted to chuck myself over a bridge and drown... if it weren’t for ChildLine, I know I wouldn’t be here right now.’¹⁶⁸

For more information, readers may refer to NPC’s report on child abuse, *Not seen and not heard*.

Personal support and representation

Young people admitted to psychiatric inpatient wards find the experience frightening and distressing. In some cases, young people say it makes their health worse rather than better. Charities, including some YIACS, play an important role in helping young people in inpatient care, lobbying for better services and supporting them after they are discharged from hospital. By acting as their advocates, they give vulnerable young people a voice; this can be particularly beneficial for young people with communication or learning disabilities who might otherwise struggle to express their concerns.

Barnardo’s Marlborough Road Partnership in Cardiff is a YIACS-style service run by Barnardo’s, a leading children’s charity. It set up its *Caterpillar Service* in April 2004 to work primarily with young people who had been admitted as inpatients at an adolescent unit in Cardiff. However, it now also works with many young people in the community: taking young people on outings, running groups and providing personal support to build their self-esteem. The inpatient work supports young people through the hospital admission process, advocating on their behalf and helping them adjust to inpatient life. A project worker from the service goes into the unit once a week to run activities and provide social support. As one project worker commented, ‘It’s important that young people are able to have a part of their life that focuses on them as a person rather than just what is wrong with them.’ The workers continue to support the young people after they leave hospital. This helps them to reintegrate into their community, make friends and improves their chances of staying healthy.

The Zone, a YIACS service in Plymouth, has child and youth advocacy services which support young people through statutory reviews, child protection cases and in making complaints to local authorities. Another YIACS, **Croydon Drop In**, addresses a huge range of needs through its advocacy and advice service—from helping young people to register with a GP, claim benefits or find housing, to liaising with social services and getting into education, employment or training.

* Online surveys tend to result in a sample biased towards younger people, so the actual proportion is likely to be lower than this.

Up to 40%
of refugee
children have
mental health
disorders.

A new project, called **Maze Advocacy**, is also developing specialist advocacy services for 6–19 year olds with mental health problems in Cardiff and Somerset. The project is in its early stages and is currently being evaluated. In early 2009 it is also due to publish a guide entitled *Through the Maze*, which will be designed to inform local authorities, commissioners and other organisations about the development of advocacy services for children and young people with mental health problems.* Maze Advocacy plans to disseminate this guidance through training workshops.^{169, 170}

Targeted support for vulnerable groups

A range of charities focus on supporting children and young people who are at particular risk of developing mental health problems, as discussed in Chapter 1.

Young refugees and asylum seekers

Up to 40% of refugee children have mental health disorders such as post-traumatic stress disorder and depression. Others may suffer from anxiety and emotional problems related to their isolation.⁶¹

The Medical Foundation for the Care of Victims of Torture deals with the physical and emotional repercussions of torture and exile through its centres in London, Birmingham, Manchester, Newcastle and Glasgow. It also works on policy and legal issues, for example providing resources about torture for lawyers. Services are sensitive to linguistic and cultural differences; there are some 80 interpreters who speak 65 languages and are matched to children, adolescents and adults according to language and gender, wherever possible.

The Foundation has a specialist Children and Family Team that supports several hundred child refugees and asylum seekers every year, mostly in London. Child refugees may have been tortured or witnessed the torture of others, including their parents. The team uses counselling, psychotherapy, group work, art, music and story-telling to help the children and young people to understand and cope with their experiences. Readers may like to refer to NPC's report on young refugees and asylum seekers, *A long way to go*, for more information.

Children in poor health; children with learning and other disabilities

There is much that can be done to support children and families where there is chronic ill-health or disability. NPC has researched this area extensively, and found that not only can the children themselves become happier if well-supported, but their siblings also benefit

from help. Charities working with disabled or sick children do not present themselves as mental health charities, but they are involved in improving well-being.

Readers may like to consult the following NPC reports: *Ordinary lives* (disabled children); *Valuing short lives* (children with terminal conditions); *A life less ordinary* (people with autism); and *Making sense of SEN* (children with special educational needs).

Young offenders

The Brandon Centre (see Box 19) is running a trial to test the effectiveness of multisystemic therapy (MST) in reducing re-offending by persistent young offenders aged 13–16. NPC will be looking at charities that work with young offenders in more detail in a forthcoming report.

Black and minority ethnic (BME) groups

Many BME young people would benefit from specialist support that takes into account cultural and religious sensitivities. For example, some BME young people worry that if they seek professional help they will be seen as 'going outside the family'.



Photograph supplied by Beatbullying

* This will be available from the Maze Advocacy website: www.mazeadvocacy.net.

Some BME young people worry that if they seek professional help they will be seen as ‘going outside the family’.

Others may be concerned that a family doctor from within their community may not keep their issues confidential. In addition, language barriers may put some young people off seeking help, or leave them feeling confused and isolated.

YoungMinds’ research, *Minority Voices*, provides case studies of 20 exemplary services working with BME young people throughout the UK.⁶⁴ Many local counselling services have developed considerable expertise in working with BME young people. For instance, **42nd Street** (see Box 18) has a South Asian women’s counselling service that understands the cultural, racial and religious issues that young Asian women may experience, and provides a safe and confidential setting in which to explore problems, thoughts and feelings.

YCSA (Youth Community Support Agency) offers activities and support for young people from BME communities in Glasgow. It runs youth clubs providing activities from arts and outings to sports and games, as well as courses to improve literacy and numeracy. It also provides specialist mental health support through counselling, advocacy and drug and alcohol work, and training for professionals working with BME young people.

Trinity Centre is a community organisation working in Newham, east London. One of England’s most deprived and ethnically diverse boroughs, Newham suffers from a lack of appropriate mental health support for BME groups and refugee children. Trinity Centre provides advocacy support that helps these children access mainstream services, such as school, foster care, or legal support on asylum claims.

The Muslim Youth Helpline (MYH) provides culturally sensitive listening and support to Muslim youth in the UK. This is available nationally via the telephone, email, internet and a face-to-face befriending service in the Greater London area.

Box 21: Keeping things together

Jane and Chris have a 12-year-old son called Tom. Tom has a long history of school exclusion and was in regular contact with local CAMHS. Jane describes how Laura, the support worker from Family Action *Building Bridges*, worked with Tom and ‘helped us keep things together’:

‘Laura was very good... she tried to do things with him, and talk things through, to raise his self-esteem. She really helped us by not blaming us, supporting us through it, unlike CAMHS who we felt were blaming us. They weren’t willing to listen to us... But Laura got a lot of information for us about attachment disorder and strategies you can use. If something she suggested last week didn’t work, then she’d suggest something else. Mostly the support came from the fact that she was willing to listen to us ... it was a big benefit to our family life.’

Deprived children

Kids Company works with some of the most deprived and vulnerable children and young people in London, meeting their emotional and practical needs and helping them back into education, training and employment. It runs three main services:

- *Arches II*: A street centre in south London that supports children and young people up to the age of 23, many of whom refer themselves to the centre or are referred by their peers. They include children and young people who have experienced trauma and neglect, and been involved in drugs, gangs and prostitution. The centre is designed to offer the sort of sustained care and ‘family atmosphere’ that they have lacked in their lives. It addresses their practical and emotional needs through services including psychotherapy, counselling, youth offending programmes, and advice on issues like drug prevention, sexual health, housing and employment. It also offers nutritious meals, a needs-tested living allowance, and opportunities to take part in activities such as sports, art, music and drama clubs.
- *The Urban Academy*: A centre in south east London for young people over the age of 16 who have rejected or been excluded from mainstream education due to their emotional and behavioural difficulties. The Academy offers structured educational courses in both academic and non-academic subjects, including life skills and creative arts, and assistance with access to further education, training and employment. Like Arches II, it aims to improve mental and physical health by providing a needs-tested living allowance, therapeutic and psychiatric support, housing advice, nutritious meals and access to a gym.
- *Schools service*: Kids Company provides therapeutic support for children with emotional and behavioural difficulties in 33 inner-city schools in London. This includes one-to-one counselling, art, play or drama therapy, family therapy, and social work to resolve issues such as child protection.

In 2007 Kids Company supported approximately 12,000 children and young people through these services.¹⁷¹

2. Tackling risk factors

Charities helping at home

Parents (or carers) are the most important influence on a child's early mental health development. Their support remains vital throughout the difficult transitions of adolescence and early adulthood. Charities that help to improve the quality of parenting therefore play an important role in promoting good mental health. NPC plans to cover parenting in more detail in a future report. Here, we highlight a few of the charities that are working with parents specifically to prevent the development of mental health problems.

The **Anna Freud Centre** in north London runs a parent-infant project which provides help for families who are struggling with issues such as postnatal depression or an unsettled baby. It also has four parent-toddler groups—two at the centre and two in the community—offering help and support to families having problems with toddler parenting. The parent-infant project has developed special programmes for high-risk groups (such as homeless families, and female prisoners with babies) who do not have access to medical and mental health support. An evaluation of the clinical service in 2002 showed that, following therapy, 80% of the babies were no longer at risk. The Centre is currently running a randomised controlled trial to identify the specific benefits of parent-infant psychotherapy for infants whose parents have mental health problems.

Children whose parents have mental health problems are at high risk of experiencing problems themselves, either through genetic inheritance, or through the effects of their parents' behaviour. Children are often confused and upset by their parents' behaviour, and struggle to form the sort of close bonds that are so important to healthy development.

Family Action's Building Bridges projects support families where a parent has, or is at high risk of developing, a serious mental disorder. Working with the whole family, it improves parenting skills, and helps the child to understand their parent's illness through play and pictures (see Box 21).

The projects are very effective: 84% of families felt that *Building Bridges* helped prevent deterioration in their family relationships and improved their children's understanding of mental illness. A recent evaluation of the projects shows that there was a 41% reduction in the number of clinically significant mental health problems experienced by parents. There were also reductions in the levels of depression in children aged 11 or under, in the number of

children in care, and in the number of children on the child protection register.¹⁷²

Young people with mental health problems may be parents themselves. Teenage mothers have a significantly higher proportion of mental health problems (especially depression) than older mothers. There are links between teen pregnancy and poor mental health outcomes, for both parents and children.⁵⁰ *Teens and Toddlers* is a programme run by the charity **Children Our Ultimate Investment (COUI)** that aims to reduce teen pregnancies and support young people. It has been effective in reducing the pregnancy rate among 'at-risk' groups of teenagers to 2.7% (the national average is 4.1%), and has a range of other positive outcomes in terms of attitudes and behaviour.

Community organisations often work with families in their local area. For example, **St. Mark's Family Centre**, a drop-in centre in a deprived area of south London, runs parent and toddler groups and mental health groups to support parents. **South Side Family Project** in Bath provides practical support to help families cope with difficulties.

Mental health problems may sometimes be triggered by bereavement. For donors interested in this area, NPC could undertake a short piece of additional research, as there are several charities, such as **Winston's Wish**, who are expert in dealing with children affected by loss.

Charities working in schools*

Charities working in schools can take two main approaches to improving mental health:

- 'targeted' interventions with children who already show mental health problems or are at risk of developing them; and
- 'whole school' interventions aimed at promoting good mental health and preventing mental health problems throughout the school population.

Many charities offer both approaches.

The Place2Be provides therapeutic counselling for children in primary schools throughout the UK. The work it does ranges from a drop-in centre ('The Place2Talk'), where children can come to talk about their everyday worries, to long-term one-to-one counselling for children with more serious difficulties, and support for their parents. Counselling is provided by volunteers, who are either qualified counsellors or in counselling training. Their work is closely supervised by qualified counsellors based in the schools. Last year The Place2Be worked with 35,000 children in 128 schools and provided over 3,000 hours of counselling to parents.

There are links between teen pregnancy and poor mental health outcomes, for both parents and children.

* NPC's education overview *On your marks*, and our report on truancy and exclusion, *School's out?* discuss the mental health of children at school.

One child in four is the victim of bullying. Bullying can lead to depressive and suicidal thoughts.

The Place2Be's results, based on several years of systematic evaluation, are impressive: 65% of children and 89% of parents show increased well-being. Counsellors are located permanently within the schools where they work and become a regular feature of school life. This makes it easier for children to seek help and minimises the sense of stigma. As one Place2Be counsellor put it: *'It can be difficult for families if a child is referred to the Children and Adolescent Mental Health Service because then they think of themselves as patients, whereas the ethos of The Place2Be is that, sometimes, we all need a bit of support.'*¹⁷³ There is a dedicated Place2Be room within each school: a bright, friendly and welcoming environment where young children can come and explore their difficulties through talk or play.

Bullying is a serious risk to mental health in the school environment. One child in four is the victim of bullying. It can lead to depressive thoughts and, in extreme cases, to suicide.^{43,174} NPC investigated bullying as part of its report *On your marks*. One of the charities featured in the report, **Beatbullying**, runs group sessions and develops anti-bullying policies in schools and youth groups. It also campaigns to raise awareness of the problems associated with bullying. Its results are impressive: teachers and youth workers report that incidences of bullying drop by 43%, and over half of young people say that working with Beatbullying has made them feel more confident. Charities like The **Place2Be** also tackle bullying by helping children work through the issues that might be at the root of their behaviour.

Box 22: Building confidence

Children come bounding in to the Pyramid club held after school at Yeading Junior School in Hillingdon. On the afternoon of NPC's visit, ten eight year olds are gathered with three Pyramid workers for an hour and a half of games, snacks and circle time. The staff (one co-ordinator and two volunteers) were young, approachable and enthusiastic, and the children were clearly pleased to be there, happily entering into all the activities and chatting freely in circle time.

A report on the Pyramid project in Hillingdon (2007) opened with a quotation from one of the children, Nagma: *'When I was a member of the Pyramid club, it felt like my home.'* For the report, the project co-ordinator asked the teachers of 177 children who took part in Pyramid clubs to rate the changes they saw in the children over the term. Only 7% were thought not to have changed, with 79% showing positive and 14% exceptional change after the term.⁷

This feedback echoes the findings of another report, published in the journal *Child and Adolescent Mental Health* in 2007. Here, researchers used Goodman's Strengths and Difficulties Questionnaire to measure changes in the social and emotional well-being of two groups of children from schools in Ealing, west London: 42 children who attended a term of Pyramid clubs, and 52 of their classmates who did not. After the term, both groups had improved, but the improvement in children who had attended Pyramid clubs was significantly greater. This suggests that Pyramid is effective in improving the social and emotional health of vulnerable children beyond what may be explained by normal developmental changes.¹⁹

According to **Pyramid**, a project run by the education charity, ContinYou, teachers note that up to one third of children in primary school are overly quiet and withdrawn. This can hamper their progression in class—at work and at play—and foreshadow problems in adolescence and later life. Research has shown that children who have difficulties interacting with others are less likely to be rated favourably by their teachers or perceived as likeable by their peers. They are more likely to have low self-esteem and are at higher risk of failing to fulfil their potential than more confident and sociable children.¹⁹

Some charities run preventative programmes that aim to identify these issues in their early stages and stop them from developing into more serious mental health problems. For instance, **Pyramid** helps primary schools in England, Wales and Northern Ireland to run weekly after-school clubs for children who teachers have identified as shy and lacking in self-esteem. The activities in these clubs are aimed at boosting the children's confidence and developing their social skills, as well as being fun (see Box 22).

Barnardo's Marlborough Road Partnership

in Cardiff is developing a *Bounceback* project for 15 and 16 year olds in local secondary schools. Teachers refer young people with emotional health problems to the charity's support workers, who come into the schools two mornings a week. The support workers look at the issues that are affecting these young people. These could include bereavement, bullying, stressful family relationships or more practical issues relating to housing, health, employment or training, which are often associated with the transition to adult life. They provide advice and help them develop the practical and emotional skills they need to cope with their problems. *Bounceback* also runs workshops for sixth form groups, to discuss emotional well-being and debunk the myths relating to mental health.

Samaritans has produced an emotional literacy course for secondary schools called *Developing Emotional Awareness and Learning (DEAL)*. Teachers and students say that it has given them confidence to deal with emotionally difficult situations. Another charity attempting to improve the school environment is **Antidote**. It helps schools to promote emotional literacy by using a survey to assess the quality of relationships within the school. It then develops strategies to address the needs identified by the survey. For example, it provides recommendations for teachers on incorporating emotional and social skills into teaching plans, and monitors changes over time.

Donors interested in supporting whole-school approaches need to be aware that they are often difficult to evaluate. Their success is also very dependent on the priorities of the school's management team. Unless the management is willing to commit resources and attach status to emotional literacy programmes, little headway is likely to be made in changing the school environment.

Charities improving local communities

As children grow up they spend less time in supervised environments such as home and school, and more time out in the community. Ideally, the activities that they take part in should give them opportunities to enjoy themselves, make friends, improve their confidence and self-esteem, and, when problems arise, find help from the peers and adults they come into contact with. In recognition of this, **Paul Hamlyn Foundation** and the **Mental Health Foundation** recently announced a new project to develop ways of supporting 16–25 year olds in the places where they spend most of their time (see Box 23).

Young people are more likely to have good mental health if they live in healthy, safe communities with opportunities for play, exercise and socialising. NPC's report on out of school hours activities, *After the bell*, provides examples of charities that promote emotional well-being through activities based in schools and in the community. Few measure their results in terms of children's mental health, but many report improvements in young people's self-confidence and communication skills.

Conversely, prejudice, tension and violence undermine mental well-being. Drug abuse, crime and a gang culture thrive where teenagers are disaffected and grow up with a lack of positive activities to engage them. These factors contribute to poor mental health.

NPC's report *Side by side* discusses charities working with young people in divided communities, whilst the report *Local action changing lives* describes community organisations tackling poverty and social exclusion. **FARE** (Family Action in Rogerfield and Easterhouse) is a grass-roots charity in Glasgow run by local people. It leads anti-gang work in 14 primary schools to tackle how and why local territorial issues first arose. FARE also offers clubs and activity groups for around 2,800 children and young people each month, runs health education campaigns, and provides adult mentors for disaffected young people. One project aimed at improving relations between local young people and the police led to a 79% drop in reported crime in the area. This has a significant impact on improving the well-being of young people locally.

The Tulloch Trust and The Broomhouse

Centre are two examples of charities working in deprived communities in Scotland. They offer arts and sports clubs, counselling, mentoring and befriending, and young carers groups. At first glance, neither of these could be described as 'mental health charities'. However, by providing activities in a friendly environment and offering a listening ear to vulnerable children and young people, the charities are able to address the problems and risks of growing up in poverty, and so increase participants' well-being. An evaluation of one of Tulloch's teenage programmes found that 90% of participants became more aware of the dangers of drugs and alcohol; 87% of participants reported an increase in confidence; and teachers reported that nearly half of the participants' behaviour improved.

The relationship between the charities and participants is lasting. The manager of Broomhouse summed up the centre's work as providing 'love and affection for people who don't have much in their lives'. Similarly, the Director of Education in West Dunbartonshire commented that: *'The Tulloch Trust is remarkable and unique for the "wraparound" care and support it gives to some of the most vulnerable young people in our community, supporting them from 8 to 20 years. It makes a very important contribution to minimising the NEET group—those not in employment, education or training—through the activities and challenges it provides, and in raising young people's self-esteem and self-confidence.'*

Mentoring and befriending programmes can also help children and young people overcome emotional problems. For example, the charity **Chance UK**, in north London, matches children with behaviour problems with adult mentors who they meet once a week for a year. One third of the children it works with have been excluded from school and most receive free school meals, a well-recognised indicator of poverty.

The manager of Broomhouse summed up the centre's work as providing 'love and affection for people who don't have much in their lives'.

Box 23: Right Here—providing support in places where young people go

A new five-year project run by Paul Hamlyn Foundation and the Mental Health Foundation, *Right Here* aims to improve the mental health of 16–25 year olds. It will work with up to five local pilot projects, delivering services in the places where young people spend time, whether schools, youth clubs or online. This aspect of the programme is key: young people do not necessarily want to be treated in clinics, hospitals and GP surgeries; they need help in places where they go and where they feel comfortable.

Each pilot will aim to build resilience in young people, their families and communities, and promote positive mental health. Young people will be heavily involved in all aspects of the project's development from design to evaluation. It will also tackle the stigma attached to mental illness that often stops young people asking for help. *Right Here* will focus on innovative ways to improve mental health and will invest in partnerships between public and voluntary sector organisations across the UK.

For more information go to: www.right-here.org.uk.

Children spend two to four hours a week with their mentors doing fun and educational activities. The aim is to develop a relationship of trust and respect, and to work towards goals for achievement and behaviour that they set themselves. For many, this will be the first time they have really been listened to and guided by an adult, and the first time they have been challenged to raise their aspirations. The charity's caseworkers also support the parents of children at risk, helping them to address problems at home.

Chance UK measures its results using a respected questionnaire for assessing children's emotional state, behaviour and ability to form relationships (Goodman's Strengths and Difficulties Questionnaire). This demonstrates an impressive change over the year: 98% of children show an improvement in their behaviour between the start and end of the programme; and by the end of the year the behaviour scores of over half of the participating children have fallen below

those associated with behaviour problems. Nine-year-old Tajchan, for example, used to be a shy, withdrawn boy who had frequent temper tantrums as he did not know how to express himself. But after a year with Chance UK he is friendly, confident and has learnt to control his temper. His mother said: *'His schoolwork has improved, too, and the way he talks to his teachers. Everything across the board has completely improved.'*

Teenagers tend to look to their friends for help in the first instance, so strengthening their capacity to help each other is beneficial. Peer mentoring and befriending schemes offer promising approaches, and the DCSF is funding a Peer Mentoring Pilot project in 180 secondary schools in England, managed by the **Mentoring and Befriending Foundation**. However, the evidence base is still quite undeveloped. A discussion of what makes an effective mentoring or befriending scheme can be found in NPC's *Lean on me* report.

At a broader level, the **Young Foundation's Local Well-being Project** is an ambitious three-year programme to test out different ways of changing whole communities. It aims to improve public well-being in partnership with the local authorities in three areas of England: Hertfordshire, Manchester and South Tyneside. Two of its five main themes are building emotional resilience in 11 to 13 year olds, and developing parenting skills:

- Emotional resilience: since September 2007, almost 2,000 11 year olds attending secondary schools in the three areas have been taking part in a programme which aims to build emotional resilience. Based on the *Penn Resiliency Programme*, developed at the University of Pennsylvania, it develops cognitive-behavioural and social problem-solving skills, taught by specially-trained teachers. The programme has had promising results in the US and elsewhere. This is the first trial in the UK, and the largest to date in any country.
- Parenting: the *Local Well-being Project* is exploring how to build on and improve existing parenting programmes in the three partner areas. These include a range of targeted and open-access services, some of which are focused on preventing antisocial behaviour.

The *Local Well-being Project* will also be investigating how best to measure well-being in communities—a significant challenge.

Box 24: The role of national children and youth charities

The major children and youth charities work with large numbers of vulnerable children, including children who have been abused, children in care, young refugees and asylum seekers, and young offenders. Mental health underlies many of the problems they tackle, and increasingly these charities have designated strands of mental health activity. For example:

- **Barnardo's** Marlborough Road Partnership in Cardiff provides a range of mental health services including the *Caterpillar Service* (see above) and *Bounceback*, a therapeutic service in schools.
- **The Children's Society** works with specific groups, eg, refugees and asylum seekers, disabled children and young offenders. It is also conducting the *Good Childhood Inquiry*, an independent national inquiry into childhood, which has a focus on children's mental health. This is gathering the views of children, young people and adults about childhood in the UK today in order to identify the most pressing issues and develop recommendations to improve the experience and understanding of childhood.
- The **NSPCC** offers therapeutic services for children affected by abuse. It runs **ChildLine**, a 24-hour helpline for children in distress or danger.
- **Action for Children (NCH)** is doing research into resilience and emotional well-being, but it is at an early stage. Its *Growing Strong* campaign aims to raise awareness about the impact of emotional well-being and resilience on young people's futures.
- **The Prince's Trust** recently piloted an *Emotional Well-being Initiative* to improve the resilience and mental health of 16–25 year olds taking part in its *TEAM* programme in three London boroughs. *TEAM* aims to help disadvantaged young people move into education, employment or training. At the beginning of the 12-week programme, the Trust used a new screening tool to assess participants' emotional needs, which were then addressed during the course of the programme. Staff received mental health awareness training to help them identify problems and decide whether young people need to be referred to external agencies for specialist help. Sessions on positive coping strategies, self-esteem, problem solving and healthy living were also incorporated into the programme. The pilot was funded by the King's Fund and an evaluation will be published in Autumn 2008. The Trust hopes to test the initiative further in other regions and, eventually, roll it out to every *TEAM* programme (8,000 young people take part every year) and other Prince's Trust projects.¹⁸

3. Changing society

Campaigning and policy

The campaigning voice for children and young people's mental health is limited relative to other sectors, and the scale of the problem is not well understood by the public. **YoungMinds** is the main charity that is active on this front. It has successfully campaigned for policy changes, such as age-appropriate inpatient care for all young people under 18. It is also proactive in trying to raise awareness through the media, and has recently announced a new campaign to improve young people's involvement in mental health services across the country. However, YoungMinds is not yet a household name in the same way as adult mental health or children's charities that have the resources and fundraising capacity to drive high-profile national campaigns. In terms of profile, there is no equivalent of Shelter or the NSPCC when it comes to children's mental health.

The large national children's charities do campaign around children's well-being in a broad sense, and some focus on mental health issues (see Box 24). **Action for Children** (formerly NCH) is developing its *Growing Strong* campaign to raise awareness about the impact that emotional well-being, self-esteem, social skills and resilience have on young people's futures. **The Children's Society's** *Good Childhood Inquiry* also has a broad focus around child well-being with some more specific work on mental health. **Samaritans'** strong brand and growing reach with children and young people puts it in a good position to raise awareness around emotional health, but it has limited campaigning capacity at present.

In Scotland, the **Scottish Development Centre for Mental Health (SDCMH)** and **Penumbra** are two charities that contribute to national policy on children and young people's mental health (see Chapter 3). They are also involved in helping both government and local agencies to translate policy aspirations into practice.

Penumbra represents children and young people's mental health issues to policy-makers, particularly in relation to self-harm (one of its specialisms) and champions young people's involvement in the development of services.

In Wales, **Barnardo's Cymru** is campaigning for specialist services and support for 16 to 17 year olds, which it has identified as a gap in current provision.

Tackling stigma and raising awareness

Mental health is poorly understood and many people feel ashamed to admit that they have a problem. However, in order to tackle issues early, it is important that young people feel that they can seek help. Lack of understanding

causes distress and confusion to those who are suffering, and leaves them feeling isolated.

Adult mental health charities are using their greater campaigning presence to contribute to broader public perceptions about mental health. For example, Mind, Rethink, Mental Health Media and the Institute of Psychiatry are currently running a major £18m campaign in England called *Time to Change*, which was previously known as *Moving People*. Though focused primarily on severe mental health problems in adulthood, it aims to improve negative public attitudes about mental ill health more widely. It plans to do this by training 10,000 doctors and teachers to be more aware of mental health issues, and training people who have experienced mental illness to speak out and challenge discrimination. It is also establishing 28 regional community projects to help 25,000 people develop healthier lifestyles. *Time to Change* has measurable aims including a 5% decrease in mental illness and a 5% reduction in discrimination within five years.

In order to tackle mental health problems early, it is important that young people feel that they can come forward and speak out.



Photograph supplied by Family Action

Training professionals who have regular contact with children and young people is vital.

See Me is the national campaign for tackling stigma in Scotland. Launched in 2002, it is run by an alliance of five Scottish mental health organisations: Penumbra, National Schizophrenia Fellowship Scotland, Scottish Association for Mental Health, Royal College of Psychiatrists (Scottish division) and the Highland Users Group. The campaign is running advertisements on TV and radio, distributing posters, leaflets, postcards and factsheets, running two websites, and speaking at meetings and conferences.

See Me has developed a campaign specifically targeted at children and young people, called *Just Like Me*. Developed after consultation with over 1,000 young people, this included a series of advertisements and a website, www.justlikeme.org.uk, which gives them a chance to discuss their experiences. It also provides useful information and guidance both for children and young people and their parents, families and other adults.

In the past, the **Royal College of Psychiatrists** has run public education campaigns to combat stigma and improve understanding of mental health problems. In particular, the five-year *Changing Minds* campaign (1998–2003) targeted groups including children and young people, doctors, employers, the media and the general public.

The media is extremely influential in shaping public perceptions. Some charities are therefore focusing on working with journalists to encourage more balanced coverage. For example, **beat** campaigns to ensure that eating disorders are presented in an informed and balanced way in the media. It supplies technical information and background details for journalists. Staff also participate in national and local TV and radio programmes, and provide broadcasters with access to young people prepared to speak about their experience of an eating disorder.

Samaritans has worked with the Press Complaints Commission to improve the way suicides are reported in the media. It has developed guidelines for the responsible reporting of suicides since links have been made between suicide rates and media coverage of suicide.

Other charities aim to improve children and young people's understanding of mental health issues by running activities to raise awareness in schools. For example, **Central YMCA**, supported by the Wellcome Trust, has a travelling theatre company called Y Touring that visits schools around the country. It performs plays that explore controversial health and science issues, including the stigma associated with mental health problems and the ethics of brain research. The performances are designed to provoke debate and are followed by a session when young people can discuss the issues raised.

4. Improving the sector

A number of charities are helping to improve the quality of services and the capacity of the sector through training, research and consultation with children and young people. Charities are often able to provide a valuable independent perspective. They can produce resources such as training programmes or publications that statutory services do not have time or ability to develop, and can gather feedback from young people about their views of services.

Training

Many frontline professionals working with children and young people—including teachers, youth workers and social workers—lack confidence and expertise in dealing with mental health problems. They receive little or no specialist training, which means that they may not recognise the signs of mental health problems, and may not know how to support or refer someone in need of help. Yet, with the right training, there is a great deal that they could do. The manager of **Barnardo's Marlborough Road Partnership** noted that: *'As professionals, we have tended to rebuff mental health in education and social services. We would rather it was dealt with by psychiatry because dealing with people who are cutting their arms to pieces isn't very pleasant and we want a quick fix. But there aren't any quick fixes... We as adult professionals need to realise we can work with young people with mental health problems. That's what young people want us to do, not keep referring them on.'*¹²⁷

Training professionals who have regular contact with children and young people is therefore vital. The **Institute of Psychiatry** and mental health charity **Rethink** are running a joint project to identify the needs of school nurses and train them how to tackle mental health problems, particularly depression and self-harm. The *Quest* project (Quality Improvement Evaluation for School Nurses and Teachers), is a three-year trial that will train school nurses and develop materials for teachers and families. It aims to improve support for children and young people with mental health problems at school and in the home. A pilot project has recently been completed in one PCT and secondary school, and the project is now launching the main trial across 13 London PCTs.

A number of charities working with specific conditions or issues provide specialist training. For example, **beat** trains professionals from education, health, social care, counselling, and fashion backgrounds. Courses range from providing basic information on the signs and risk factors of eating disorders, to raising awareness of the patient's experience of receiving treatment. Training should improve rates of diagnosis and access to treatment, as well as improving the

quality of care sufferers receive, although its impact can be difficult to evaluate.

Youth Access runs a variety of training courses specifically tailored to the needs of YIACS. These cover a wide range of issues, including accredited training for youth counsellors and workshops on advice skills and issues such as outcomes monitoring, welfare benefit rules, and homelessness legislation. These courses, and the regular networking events that Youth Access runs, also give staff from YIACS a chance to share experiences with their counterparts from other YIACS across the country.

The Place2Be provides training to teachers, assistants, learning mentors and other professionals. It has also developed foundation, postgraduate diploma and masters courses with the University of East London in working therapeutically with primary school aged children. **Samaritans** has produced a self-harm response kit for schools, and a training programme for teachers.

Mental health professionals benefit from ongoing training, and charities can often provide an independent perspective. **YoungMinds'** training helps to raise awareness of children's needs (see Youth participation below), and promote collaboration across health, education, social care and voluntary workers. It also has a consultancy service which supports professionals in local authorities and mental health services—commissioners, managers, and practitioners—to improve the way they plan, prioritise and deliver services. The **Trust for the Study of Adolescence (TSA)** provides an extensive range of training programmes and resources on a variety of youth issues, from supporting young fathers to living with teenagers in foster care.

At a more academic level, the **Anna Freud Centre** offers masters courses in developmental psychology and neuroscience. It also runs a range of short courses in specific issues such as personality disorders and parenting, and methods of assessing children who have experienced trauma or family separation. As part of its work with the CAMHS Evidence-Based Practice Unit, it runs an annual 'Outcomes-based leadership in CAMHS' course for NHS managers and practitioners, helping them to develop and lead the services they manage. In total, the Anna Freud Centre trains over 1,000 mental health professionals every year.

Youth participation

'Youth participation' means involving young people in the design and delivery of services so that their needs are put first and it is not simply assumed that clinicians 'know best'. It means asking young people about their experiences of mental health services, and what they want

to happen, and then using this information to improve the way treatment is delivered.

Historically, young people's views have not generally been taken into account.⁴⁹ This situation is starting to change and charities are at the forefront. Increasingly, charities have youth advisory boards and young people are involved in decisions about how things are done. At Barnardo's Marlborough Road Partnership, for example, young people interview prospective staff to ensure that they are people they feel they can trust and get on with.

Charities such as **YoungMinds** and the **Mental Health Foundation** have highlighted children and young people's perspectives and problems with existing services. YoungMinds has a group of young people, 'Very Important Kids' (or VIKs), who are involved throughout the charity: in developing YoungMinds training, policy and consultancy work, and raising awareness of mental health problems. For example, they recently contributed to 11 Million's progress report on young people's experience of adult psychiatric wards, *Out of the shadows?*¹³⁴ Young people are being consulted about the MHF and Paul Hamlyn Foundation's *Right Here* project, and will continue to participate in its development and evaluation.

Penumbra has been involved in a partnership project with Children In Scotland and Barnardo's to improve young people's participation in issues that affect their mental health and well-being. The **Scottish Development Centre for Mental Health** also consulted large numbers of children, young people and parents on their understanding and experiences of mental health problems and services as part of the *Scottish Needs Assessment Programme (SNAP)*.

It is essential that young people's views are not only sought, but actively used to develop services and train professionals—otherwise participation can be tokenistic. The *Experience in Mind* project, developed by **Mind in Brighton and Hove** and **Hove YMCA**, is a good example of how charities can help ensure that young people's views are fed into service development. It is an innovative project that brought together young volunteers to design and deliver training for professionals, parents and other young people, using their own experiences of mental health problems and services. Training covered topics like anxiety, stress and depression, communication and self-harm, and included films and recordings developed by young people to give participants a better understanding of a young person's experience of mental health problems.

Giving young people the opportunity to take the lead can also benefit their mental health. As one young person who was involved in the *Experience in Mind* project commented:

Young people's views should be sought and actively used to develop services and train professionals.

Giving young people the opportunity to take the lead can also benefit their mental health.

Research by YoungMinds has been instrumental in highlighting the lack of appropriate inpatient care for children and adolescents.

Charities can help to build the evidence base by rigorously evaluating their results.

'I was on a downward spiral literally right at the bottom, and the things that have helped me to get back up is like getting a job and joining this project—it gave me something to focus on and when I started achieving the things I was achieving it made me feel even better.'

Introducing youth participation need not be arduous. It is more about charities promoting an open, consultative approach and asking themselves some potentially difficult questions about what they are doing and whether they are really meeting young people's needs. One charity that is doing this is **Samaritans**, which is currently undergoing an evaluation to understand what its users want, and what difference its support makes. For example, Samaritans has learnt that children and young people who contact its helplines sometimes want more practical advice and suggestions, as opposed to adults who prefer 'non-directive' support and a listening ear.

Research

Charities make an important contribution to research on two levels: drawing attention to sector issues and developing the evidence base for particular interventions.

Highlighting sector issues

Research into sector issues helps to increase understanding of who is affected, the type of support children and young people need, and how treatment and care can be improved. Findings may be used to lobby government, raise public awareness, influence other organisations in the sector, or all of the above.

For example, research by **YoungMinds** on young people placed on adult psychiatric wards, *Pushed into the shadows*, and the recent update, *Out of the shadows?*, has been instrumental in highlighting the lack of appropriate inpatient care for children and adolescents, and in pushing for policy change.^{14, 134} Similarly, **Barnardo's Cymru** conducted research into the main issues and gaps in provision for 16 and 17 year olds in Wales, which now forms a focus for their campaigning.⁵¹

The **Mental Health Foundation** undertakes research into a wide range of mental health issues. It uses the findings of its research to make recommendations on good practice and policy. Though focused primarily on adults, it has started to conduct more research on children and young people. For example, its 2007 publication *Listen Up!* highlighted the need for accessible support for young people aged 16–25.

The **Trust for the Study of Adolescence (TSA)** uses its research to develop professional practice, rather than for campaigning purposes. TSA carries out research into issues affecting adolescents and young adults (including mental health and parenting). It evaluates the effectiveness of individual services, runs training courses and conferences, and produces practical resources such as guides and toolkits.

Building the evidence base

Charities are helping to improve sector knowledge about how to promote good mental health and prevent mental illness. Those that run direct services can contribute by evaluating their results carefully and sharing their findings with other charities and, ideally, with academics. Independent evaluation, by academics or specialist consultants, can also be beneficial and increase credibility. NPC recommends that donors should ensure that funding for monitoring and evaluation is built into any grants they make for direct services.

Some charities take an academic or pioneering approach to developing new treatments. The **Anna Freud Centre** uses its clinical practice to inform its research into child psychotherapy and psychoanalysis, and vice versa. It is particularly focused on an 'evidence-based' approach to treatment, and hosts the CAMHS Evidence-Based Practice Unit. An example of the Centre's current research is a randomised controlled trial to identify the specific benefits of parent-infant psychotherapy for infants with parents with mental health problems. Like many other research organisations, it also disseminates its results through publications and training.

Another academic charity, the **Psychiatry Research Trust**, was formed in 1982 with the aim of raising funds for research into mental illness and brain disease. It is linked to the **Institute of Psychiatry**, which is one of the leading research institutes devoted to the study and prevention of mental health problems. Current research involves a wide range of mental, nervous and brain disorders, including work on the underlying causes of conditions and means of preventing, treating, and curing them.

Research into what works with specific groups is also a priority. There is a particular shortage of information about what is effective for young people in the 16–25 age group. This group often falls through the gap between CAMHS and adult mental health services. Yet adolescence and early adulthood is the time when young people are particularly vulnerable to the onset of serious mental illnesses such as depression or bipolar disorder, and psychotic disorders like schizophrenia. These conditions

are associated with high-risk behaviour: young people with depression or bipolar disorder are more likely to self-harm or commit suicide, and psychosis is associated with aggression and substance abuse.⁵¹

Youth Access carries out research into the ways that YIACS can best support this vulnerable age group. Its research spans the different specialisms of its members. Of particular interest for this report is its proposal to run a randomised controlled trial to evaluate the effectiveness of youth counselling in a YIACS setting. If this goes ahead, it should help to strengthen the credibility of YIACS.

Collaboration

Given the fragmented and under-resourced nature of the children and young people's mental health sector, there is a need for organisations that can improve collaboration, coordinate campaigns and share resources, both between voluntary sector organisations, and with statutory services. For example, **Young Scotland in Mind** is a forum that promotes and coordinates the role of the voluntary sector in improving children's mental health in Scotland. It was launched in April 2006, and is led by Barnardo's with the aim of building the strength of the voluntary sector, sharing good practice and influencing policy. The network is now established, with around 200 member organisations, and is currently developing its strategy. For donors who are specifically interested in supporting Scottish charities, contacting Young Scotland in Mind would be a good starting point.

There is no equivalent body in England or Wales, although **YoungMinds** and **Youth Access** play important coordinating roles with a number of voluntary and statutory services. The **Emotional Health Alliance** acts as a 'learning network' to facilitate the discussion between charities and other organisations concerned with children's emotional well-being. There is also an association of charities called the **Mental Health Providers Forum**, but it is primarily focused on adult mental health.

Charities are also good at providing resources that encourage professionals to become more actively involved in the sector, take part in research and conferences, and share best practice. **YoungMinds'** magazine is recognised throughout the sector as an important source of up-to-date news and information. **beat** has a network service for professionals working with eating disorders and its 600 members

receive regular emails—sharing knowledge about current research projects, upcoming conferences and events, and job vacancies.

Professional representation

There are a number of professional bodies who represent different types of practitioners working in this sector. They play an important role in promoting collaboration and developing best practice. Again, they tend to be primarily focused on adults, but, increasingly they are developing specialisms reflecting children and young people's mental health needs.

The **Royal College of Psychiatrists** is the professional and educational body for psychiatrists in the UK and Republic of Ireland. Its role is to: represent, train and support psychiatrists; set standards and promote excellence in mental health care; improve understanding of mental health through research and education among professionals and the general public; and work with patients, carers and their organisations. It has run a number of campaigns to improve public awareness and combat stigma.

The **Association for Child and Adolescent Mental Health (ACAMH)** is a membership organisation that brings together a variety of different professionals who work to improve children and young people's mental health, including psychiatrists, psychologists, therapists, social workers, teachers, nurses and GPs. Like the Royal College, it runs training and conferences and publishes academic journals.

Leading professional bodies for specific types of therapies include: the **British Association for Counselling and Psychotherapy (BACP)**; the **UK Council for Psychotherapy (UKCP)**; **Counselling and Psychotherapy in Scotland (COSCA)**; and the **Association for Family Therapy in the UK**.

Challenges and opportunities

This chapter has highlighted that there are many charities doing excellent work in improving children and young people's mental health. But there is a lot more that they could do if the sector was not so fragmented and under-resourced. This makes it a challenging environment for charities and donors to work in. However, it also means that there are plenty of opportunities to contribute to the development of the sector and support charities to help more children and young people. These opportunities will be explored further in the next chapter.

Charities
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actively involved
in the sector.



Photograph supplied by istockphoto.com

Challenges facing charities and donors

Charities in this sector are doing valuable work in difficult circumstances. Many organisations that NPC spoke to expressed concerns about changes to local commissioning, and the difficulties of measuring results and overcoming professional biases.

Donors also face challenges when approaching the sector. How do they recognise a good counselling service? What kind of results should they expect from charities? And, in a sector under-funded in many areas, how does a donor prioritise needs?

This chapter discusses the challenges that charities and donors face in the sector. These can be grouped into three main areas:

- funding is inadequate and uncertain;
- the evidence base is incomplete; and
- the sector is fragmented.

Despite these challenges, it is important to recognise that the underdevelopment of the sector also represents an opportunity. By addressing these issues, charities and donors can make a real difference.

Funding challenges

Overall, the sector is extremely under-resourced. Almost every charity that NPC spoke to during its research said that its main challenge was to secure funding. The most striking points are:

- government funding for the sector is currently very uncertain;
- there are no 'household name' charities that fundraise nationally for children's mental health. The NSPCC has a high profile, but its fundraising activities are focused on child abuse, rather than the mental health of children; and
- charities rely heavily on grant-making trusts and foundations, but these tend to favour funding projects rather than supporting charities' central costs over the long term.

The uncertain future of commissioning

Government is in the process of shaking up commissioning arrangements. Grants from local authorities and PCTs are likely to be replaced by contracts for which charities will have to tender competitively. Commissioners and charities are unfamiliar with this process and there is considerable uncertainty about what it will mean in practice. Contracts are not intrinsically bad for charities: being accountable is a good discipline. But with the introduction of new commissioning processes, problems are emerging in the sector. These include:

- lack of clarity regarding processes and what charities should be doing to promote their case;
- commissioners not always understanding the value of charities' work or sometimes lacking the expertise to commission services in the best interest of the people they are trying to help;
- smaller charities being disadvantaged in tendering processes because commissioners may prefer to commission one big charity, rather than a series of smaller specialist charities, even if the smaller ones have better local and specialist knowledge;
- charities having to re-tender to provide existing services at a lower cost, whilst meeting increasing demand from users;
- charities lacking resources to prepare and negotiate complex tendering documents;
- charities lacking the financial flexibility to plan when commissioning decisions are made at the last minute or even after the financial year end;
- charities lacking the financial flexibility to absorb unexpected contract losses;
- reduced funding for activities that target vulnerable groups, but fall outside the immediate range of services being commissioned by PCTs or local authorities (eg, healthcare for the homeless); and
- tendering that focuses on 'outputs' rather than 'outcomes'.*

Government funding for the sector is currently very uncertain.

* Examples of outputs would be the number of people reached or the hours of counselling delivered. By outcomes we mean the impact of services, eg, measurable improvements to a person's mental health.

It is not unusual for directors and chief executives of charities to spend 40–50% of their time fundraising.

There are no big advertising campaigns, shops, or local tin rattlers to raise funds.

It is currently unclear what will happen to local authority commissioning, so it is difficult for charities to plan for the future. NPC believes that any increased costs associated with bidding and fulfilling contracts should be borne by the government. However, in order to develop and negotiate bids, charities may need financial support from other funders in the meantime.

Fundraising from the general public

The uncertain commissioning environment is compounded by the fact that the fundraising capacity of charities in the sector is very limited. Many cannot afford professional fundraisers and it is not unusual for directors and chief executives to spend 40–50% of their time fundraising. Charities that can afford fundraisers often focus on trust income, which may be restricted.*

There are no big advertising campaigns, shops, or local tin rattlers to raise funds. This has several effects: there is lower awareness of the issue generally; poor knowledge of charities working in this sector; and minimal access by the sector overall to meaningful amounts of unrestricted funding. Contrast this with, say, the palliative care sector. Through a combination of big national charities such as Marie Curie Cancer Care and strong local hospices, the sector has been able to raise abundant unrestricted funding. There has been powerful leadership from charities and, as a result, progress throughout the sector in recent decades has been impressive.

It is vital that the children and young people's mental health sector is able to grow its unrestricted income. Many charities have very limited reserves, which means that they are extremely vulnerable to changes in funding or policy. Unrestricted funding increases charities' flexibility, security and ability to respond to changing priorities in the sector. Donors should give unrestricted funding and support to *effective charities*, in place of, or as well as, funding for individual, short-term projects.

Fundraising from trusts and foundations

Grant-making trusts and foundations are active funders in the mental health sector, and for many charities they are a vital source of income. Appendix 3 on NPC's website summarises our current knowledge of funders in mental health for adults, children and young people (funding for children and young people is not always designated as a separate funding stream). In particular, the Big Lottery Fund, Comic Relief, and Paul Hamlyn Foundation are all engaged in very ambitious projects aimed at tackling

fundamental problems in the mental health sector. The latter two have a specific focus on young people.

The demise of the Camelot Foundation, which specialised in funding charities with income under £1m, is a major loss to the sector. The Foundation's expertise in cultivating small, local, youth-focused initiatives leaves a gap for many charities in the sector. It was also a pioneering grant-maker in terms of its focus on funding self-harm projects. The end to this funding is a significant challenge for the charities working in this area.

Full-cost recovery from statutory funders

Certain charities find it hard to recover the full costs of their activities from statutory funders, and are therefore at risk of making a financial loss. For example, charities that provide services in schools are competing for money against other important demands on school budgets—the choice might be between bringing in a charity to provide therapeutic support or employing two additional learning mentors. Public sector organisations are often unwilling or unable to pay for 'non-essential' workforce training, such as training provided by charities on self-harm or eating disorders, which could improve understanding, referral and care. Sometimes this means that charities rely on grant funding or voluntary donations to subsidise these services.†

However, NPC would encourage charities which provide a valuable service to statutory agencies to charge for it where possible. Some charities, such as **The Place2Be**, are able to recover a significant proportion of their costs from school budgets (25%) or obtain additional funding from local authorities (50%). The DCSF's *Targeted Mental Health in Schools* programme may also bring additional funds for charities working in schools, although it is too early to tell.

Role of the national children's charities

Mental health is an underlying issue for the large children's charities, but it has not been an explicit focus of their work. However, as they increasingly move into doing more specific mental health work, some community-based organisations have expressed concern that they will be crowded out, or that their services will be taken over. As the funding environment changes and local contracts are increasingly put out to tender, there will be a greater emphasis on costs. Large national charities have greater fundraising power and the infrastructure to bid competitively for local authority contracts.

* By 'restricted' we mean funding tied to a specific purpose or project. 'Unrestricted' funding can be used at the discretion of the charity and is often needed for core staff costs and overheads.

† For more information on full-cost recovery, charities and donors can read NPC's report *Full-cost recovery: a guide and toolkit on cost allocation*.

The increasing presence of the large children's charities in the sector is welcome, since they have the capacity and resources to improve the mental health of large numbers of children and bring wider public attention to the scale of the problem. However, it is important that local expertise and services that are trusted and embedded in their local communities are not lost. Many community organisations have an intimate knowledge of their local population and have developed in response to specific local and cultural needs. Many get referrals by word of mouth and are known for their friendly, informal approach. Ideally, commissioners and local authorities will recognise the need for both increased volume and speciality of services.

The advantages that community charities offer, in terms of being able to reach young people, provide the type of services they want, and actually secure improvements to health, may be lost on commissioners who want to manage a smaller number of larger contracts at lower cost. NPC does not get the impression that bigger players are winning contracts because they measure their outcomes better: they do not. It is often an issue of trust: commissioners may feel more comfortable commissioning statutory providers or well-known charities because the lack of a quality mark for YIACS makes it difficult to gauge their effectiveness.

The challenge of scaling up

Many charities in the sector are very small. Growth and managing the volume of need present major challenges. For example, as YIACS become better known, they face higher demand for their services and longer waiting lists. However, they are also having to deal with shorter contracts and greater financial insecurity. The local remit of YIACS is an obstacle to attracting funding from donors, trusts and foundations with a national focus (see Box 25).

There are also other challenges to growing beyond a certain size. One local YIACS service that NPC spoke to described how funders' criteria and perceptions of need can limit growth. In 2004, this charity had an income of around £700,000, which mainly came from statutory sources. The charity brought in a new chief executive to try to diversify the funding base. He was successful with many applications and managed to get income up to over £1m. However, once the charity came to be seen as 'a £1m organisation', the funding applications began to fail—it no longer met certain criteria or failed to be seen as 'a charity needing funding'. As a result, its income dropped back down to around £900,000 and its applications started to be successful again.

Box 25: Who is funding YIACS?

There is no collated financial data for YIACS services. However, as there are 470 services in the UK, with income ranging from around £50,000 to under £1.5m, NPC estimates that the total income of YIACS is in the range of £100–200m, forming by far the largest component of the sector. Much of YIACS' funding comes from statutory sources—mainly local authority funding—but from different budgets, reflecting the range of services provided, such as housing or general advice/youth work. PCTs also fund YIACS for some services. Just under a quarter of YIACS surveyed in 2006 received direct funding from CAMHS.⁴ Some YIACS have received funding from national grant-makers like the Big Lottery Fund and BBC Children in Need, but generally their low profile makes it difficult for them to attract private donors.

Many YIACS lack security at the moment because of fluctuations in funding streams, particularly for youth work, and changes in commissioning arrangements. Most have to tender for multiple contracts on an annual basis, which is time-consuming and can make planning ahead problematic.

Financial security varies enormously from area to area, and does not necessarily correlate with an ability to demonstrate results. In any case, few YIACS have had sufficient resources to invest in evaluation and measurement. One of the exceptions is The Brandon Centre, which has a more medical approach than most YIACS. The evidence of its effectiveness has clearly strengthened its case with funders at a national and local level. However, NPC suspects that the main reason that its funding is secure is because it has, over decades, become a vital part of mental and sexual health provision in its area. As well as having strong relationships with local funders, it has also been lucky—commissioning has not had a disruptive impact on mental and sexual health services where it works—and it does not rely on local authority youth services funding, which is currently in flux.

Condition specific charities

Though condition-specific charities tend to have a national reach, many are small, with an income of less than £1m. The niche focus of many condition-specific charities in the sector is a barrier to funding. Although there is a small pool of committed staff, volunteers and funders, it can be extremely difficult to reach a wider audience and engage individuals without direct experience of, say, obsessive compulsive disorder, phobias or eating disorders. Many of these charities have developed out of the experience of individual sufferers, and remain strongly influenced by these individuals. In NPC's view, this is both a strength and a weakness. They are often very effective at providing support and information, informed by the empathy and understanding of people who have experienced the same problems themselves. This shared experience helps reduce the isolation that many sufferers feel. However, these charities often remain heavily dependent on their founders and struggle to develop organisational capability or grow beyond a certain point. **beat** is a notable example of a charity that has successfully managed to professionalise its services and reach a wider audience, through a combination of strong leadership and engaged funding (particularly from the Impetus Trust). Nevertheless, it too remains small relative to the level of need and the range of its activities.

The sensitive and hidden nature of mental health problems raises ethical and practical challenges to data collection.

By demonstrating their effectiveness, charities may be able to secure better funding.

Measuring impact

Evidence of results not only helps charities to improve their services; it also helps to inform funding decisions. If charities do not properly evaluate what they do, they cannot assess whether they are having a positive impact, or where they might need development. In some cases, poor monitoring of services can mean that environments that have harmful effects on young people are not recognised. This can be a risk with poorly monitored self-help groups, for example. Evaluating the cost effectiveness of services also improves efficiency and demonstrates value to donors.

Charities should be aware that by failing to gather evidence of impact, they are missing out on opportunities for funding. NPC has met many charities which are providing excellent services, but are ‘under-selling’ themselves due to poor outcome measurement. That said, measurement is not easy, and there are a number of challenges for charities in gathering evidence about their results.

Challenges to collecting data

When visiting charities, NPC gathered a large amount of anecdotal evidence from charity staff and young people on how charities had helped, and even saved, lives. However, finding systematic evidence of results for these activities is often more difficult.

The problem is not unique to charities in this sector; in fact children and young people’s mental health charities are relatively good at measuring their results compared to other sectors that NPC has researched. However, the sensitive and hidden nature of many mental health problems raises ethical and practical challenges to data collection.

For example, helplines face particular difficulties because confidentiality obstructs charities’ ability to collect data: **Samaritans** cannot call young people back to find out if they have committed suicide, so it is difficult to establish how effective its intervention has been. Similarly, **beat** does not always know whether the young people it supports go on to see a GP or get treatment, because tracking vulnerable young people along the recovery path can be intrusive. Evidence of impact is therefore often limited to feedback from callers or those who respond to user surveys. Whilst this feedback is powerful, it is weakened by the fact that the samples are often self-selecting and the assessment of impact is not objective.

Charities that conduct training often use evaluation forms to gather participants’ feedback. Again, user feedback is selective, subjective, and does not capture the long term impacts of these interventions. Ideally, training measurement would show the benefits to, say, patient care or diagnosis rates.

Evaluating charities’ impact on individuals tends to be easier than evaluating their impact on whole groups or populations. Charities often use clinical outcomes scales, discussed below, to measure changes to an individual’s mental health problems over the course of their involvement in a treatment or support programme. It is more challenging to establish how successful preventative approaches are, or to measure improvements in emotional well-being across a whole school population. However, this does not mean it is impossible. Monitoring well-being and rates of mental health problems in the target group or population may provide a useful indicator.

Similarly, campaigning charities sometimes struggle to demonstrate their results. Simultaneous and overlapping campaigning efforts tug sometimes in the same, sometimes in different directions. Nobody can be perfectly sure that each and every one of them is making a difference, or indeed what difference each makes. The problem of attribution matters both for accountability and effectiveness. It can also be politically sensitive: in a crowded campaigning environment, an organisation can damage its relationships with present and future collaborators by ‘claiming’ a victory for itself. Attribution is less of an issue when only one organisation campaigns on an issue, or when an umbrella organisation or large coalition of charities campaign together, effectively reducing the number of distinct actors pushing for change.

However, the difficulties should not be exaggerated. As discussed in NPC’s report on campaigning, *Critical masses*, most campaigns can produce a well-reasoned, evidence-based case for why their work contributed to an observed, desired change, stopping short of trying to provide proof of its precise effect.

In the children and young people’s mental health sector many charities simply do not have resources available to commit to research and evaluation of their services, beyond user feedback forms. When resources are stretched, evaluation is the first thing to go. This is frustrating because demonstrating effectiveness can often be a route to securing better funding. Donors need to be prepared to pay for charities to evaluate their services.

Clinical outcome scales

Most counselling and therapeutic services have begun to use clinical outcome scales such as 'CORE' and Goodman's Strengths and Difficulties Questionnaire (SDQ) to measure their impact on children and young people's well-being. This is a positive step and NPC has seen some excellent examples of charities collating this evidence and using it to great effect—both to improve their own services and with funders—notably in the case of **The Place2Be**, **Chance UK** and **The Brandon Centre**.

Clinical scales work by measuring a young person's well-being at the beginning and end of an intervention, in order to determine if any improvement has occurred. Young people fill out a questionnaire during their first and last counselling session, and sometimes at regular intervals in between. This measures the progress that a young person makes and demonstrates the changes to well-being as a result of the intervention.

However, many counselling services that use clinical outcome scales still face challenges in collecting data. The extent of young people's mental health problems does not always emerge in the first session which means that

the baseline data (against which change is measured) may be misleading. Conversely, young people may stop using a service without warning, which makes it impossible to track progress at the end of therapy. To remedy these problems it might be necessary to measure progress more frequently.

Table 8 gives a brief overview of the different outcomes measures that NPC saw used by charities providing counselling services and therapy. It is difficult to make a definitive comment on which measures are most effective—each has its strengths and weaknesses. In NPC's view, the Achenbach and SDQ scales are particularly well-validated for use with children and young people. All measures generally work better when reports from children and young people are accompanied by reports from parents and teachers. There is little consistency about which scales are used throughout the sector and some charities have adapted or created their own scales. This can make direct comparisons between services very difficult.

NPC is also currently developing a non-clinical questionnaire for charities to measure children's well-being (see NPC's *On the bright side* report for further details).



Photograph supplied by The Brandon Centre

Table 8: Assessment tools used by counselling and therapy services*

Scale	Age group	Targeted at	Strengths	Weaknesses
Achenbach System of Empirically Based Assessment (ASEBA) ¹⁷⁵	Completed for 1–18 year olds by parents, teachers, and children and adolescents. (Different sets of forms for pre-school and school-age children; separate version for adults.)	Children and young people with psychological disorders.	Very well-validated and accepted by professionals. ^{49, 176}	113 questions, so some might find it onerous.
Goodman's Strengths and Difficulties Questionnaire (SDQ) ¹⁷⁷	Completed by 11–16 year olds, and by parents or teachers for 3–16 year olds.	Children and adolescents with psychological disorders.	Well-validated and accepted by professionals. Easy to use; only 25 questions.	Less comprehensive than Achenbach for diagnosis and limited internal validity for some individual scales. ⁴⁹
Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) ¹⁷⁸	Completed by all users for children and adolescents.	Children and adolescents with psychological disorders.	Sensitive and validated. Short (13–15 questions).	May not be good for specific diagnosis or deeper understanding of impact. Most validated for use by medical practitioners—less evidence for child-report form. ^{179–181}
Young People's Clinical Outcomes for Routine Evaluation (CORE) ¹⁸²	Completed by young people. There is also an adult version.	Children and young people with psychological disorders. Usually used by counselling services and focuses more on emotions and thoughts than behavioural issues.	Adult version well-validated and short. Only 10 questions on young people's CORE.	As it is brief, it may not be good for specific diagnosis or deeper understanding of impact.
Children's Global Assessment Scale (CGAS) ¹⁸³	Completed by clinicians for children and young people 'of all ages'.	Children and young people with psychological difficulties.	Popular and simple to use.	Sensitivity and specificity have not been clearly established. ¹⁸⁴
Commission for Health Improvement (CHI) Experience of Service Questionnaire (ESQ) ¹⁸³	Completed by children and young people aged nine and older, to assess experience of services rather than clinical outcomes.	Children and young people using mental health services.	Straightforward; provides clear, immediate feedback to services about areas for development.	No obvious weaknesses.
Rickter Scale ¹⁸⁵	All	Not specific, assesses general well-being.	User interaction, young people like it.	Not a clinical scale. Unvalidated and not tailored for mental health problems.

One charity that NPC spoke to had to use five different measurement forms as part of its statutory funding agreement.

A variety of measurement tools are currently used by different CAMHS services. However, the CAMHS Outcomes Measurement Consortium (CORC) and the CAMHS Evidence-Based Practice Unit (EBPU) are reviewing this and plan to recommend standard measures to be used across CAMHS so that the results of services can be compared more effectively in future.[†]

Reporting requirements: the wrong sort of measurement?

Not all measurement is useful, and NPC came across several cases where charities faced challenges in satisfying their funders' demands for onerous amounts of information.

One charity that NPC spoke to, which provided therapy to children aged 6–18, had to use five different measurement forms as part of its statutory funding agreement. Whilst this might provide valuable information about the child's progress, the practical demands of getting a distressed and anxious child—who may be depressed, self-harming or a victim of abuse—to sit and fill out five different sets of forms are likely to obstruct the therapeutic aim of the session. It is important that measurement does not become intrusive. A challenge for charities is to develop sensitive ways of collecting useful information, and feeding back to funders when reporting requirements are unrealistic.

* Based on analysis from NPC's Tools team, conversations with experts, and the sources referenced.

† At present, the protocol they recommend is: the SDQ for the parent and child perspective; the Commission for Health Improvement ESQ to gather feedback on the service from parents and children; and CGAS and HoNOSCA for the practitioner's perspective. CORC suggests that these are used at the child's first appointment and then approximately six months later. More specific measures are also being piloted that may be used in addition to these.¹⁸⁶

Conversely, some local authorities are more interested in outputs than outcomes (eg, the number of young people using a service). NPC saw examples of charities producing complex diagrams and collating outputs on the age, genders and ethnicities of its users. Although this is helpful in showing a charity's reach and user group, on its own it does not indicate how effective the service is at improving young people's mental health.

NPC's overall message to charities here is that the better the evidence base is, the harder it will be for commissioners to ignore the results. Even if at this stage commissioners are not appearing to demand good evidence when commissioning services, NPC believes that charities can play a role in educating commissioners, and thus gain an edge in the competition for scarce resources.

Fragmented sector

The lack of a well-defined or coherent 'sector' creates challenges for both charities and donors. It makes it harder for charities to develop a campaigning and fundraising profile. Donors therefore have these options:

- Support high-risk charities that might, with time and sufficient resources, be able to provide the sector with core strength.
- Support lower-risk charities that contribute to the sector, but still operate on its margins.
- Create ambitious initiatives, in partnership with existing players, to fill the sector's gaps.

Relationships between charities in this sector also tend to be weak in comparison to other sectors that NPC has analysed. This is connected to the structural problems discussed above. However, it is also the result of some other specific factors, outlined below.

Collaboration

Lack of time and resources limits the ability of charities to collaborate and develop strong networks. Many charities live hand-to-mouth

in terms of funding and are under considerable pressure to deliver services in extremely difficult circumstances. The opportunities to attend conferences, visit services in other areas, or simply 'get round a table' are often limited. There are no well-resourced umbrella bodies coordinating the efforts of the charity sector into meaningful action on a large scale, so the agenda for policy change is not well defined. There is regional collaboration in places, and charities such as YoungMinds and Youth Access, and forums such as Young Scotland in Mind, play a coordinating role to some extent. But the sector remains relatively fragmented, and this problem may be compounded in areas where charities are competing for funding.

Professional divisions

Mental health professionals are sometimes wary of charities providing services for children and young people with mental health problems. Some clinicians are sceptical about the role and competence of charities in the sector and, as a result, many charities feel undervalued by professionals.

In some cases this may reflect professional protectionism and assumptions about the superiority of psychiatry over non-medical approaches. In other cases, there is good reason for this caution. Local counselling services described the importance of 'knowing their limits' when dealing with severe mental health problems. It is important that charities are well-linked to CAMHS so that they can refer children and young people to specialist services, get advice and share best practice.

No easy answers...

There may not be any straightforward solutions, but there are many different ways in which donors and charities can help to develop this rapidly-growing sector and provide more and better support for children and young people. The next chapter will help donors to think more explicitly about how to prioritise their giving, balancing the needs of the sector against their personal interests and attitudes towards risk.

Mental health professionals are sometimes wary of charities providing services for children and young people with mental health problems.



Photograph supplied by Samaritans

Options for donors

There are many opportunities for donors to make a difference to this sector, but not all of them are straightforward. More ambitious donors might like to support charities that are developing the sector. Others might prefer to fund charities that provide targeted support to specific groups, areas or issues.

As there are clear funding needs across the sector, it can be difficult to prioritise which are the most urgent. This chapter will help donors to think through the issues, identify opportunities, and decide how to give most effectively.

Priorities for funding

The first choice for donors is between building the capacity of the sector or targeting their support towards specific issues, areas or groups of young people.

The priorities for improving the sector do not represent easy options for donors. Big sector fixes will be challenging to implement and will require resources, time and an appetite for risk. But there are exciting opportunities and NPC hopes that ambitious donors will, if necessary, collaborate to develop solutions.

Donors with fewer resources or who would prefer to fund frontline support can still make a significant impact. The different options are discussed below and in Table 9, which provides a snapshot of the needs, what is being done to address them, and the evidence for what works. Many of the charities we have referred to in Chapter 4 have activities that cut across both these approaches.

Priorities for the sector

NPC's research and discussions with charities, academics, practitioners and policy-makers have identified the following priorities for improving the sector. There are few easy options here, so this approach may be more appealing to professional funders. Alternatively, donors could choose to fund a discrete piece of research or an evaluation that would also be valuable to the sector.

Strengthen the capacity of the sector to campaign, coordinate and fundraise

Charities can play a vital role in ensuring that children and young people's needs are

understood by policy-makers, the media and the wider public. However, this sector lacks the kind of high-profile campaigning charities that NPC has seen in other sectors. The sector also needs coordination so that its collective voice is greater than the sum of its parts. Improving these areas is an urgent priority for donors and funders.

Donors might consider supporting the development of campaigning work by charities like **YoungMinds**. YoungMinds is very important to the sector, which needs an overarching charity specialising in children and young people to represent its views and to navigate a difficult policy environment. However, it is not an ideal size and significant growth in capacity and resources would better reflect the sector's requirements.

As discussed in Chapter 5, measuring the impact of campaigning can be challenging. Donors who want to support campaigning work should look for a clear strategic plan with well-defined objectives and a well-reasoned approach to how they can be achieved. Investing time up-front getting to know a charity can reduce the level of risk involved.

Youth Access, the national membership organisation for YIACS, plays a crucial role in representing local counselling, advice and support services. It already punches above its weight in terms of its links with central and regional government and other national charities. However, like YoungMinds, its work has been limited by lack of resources. With additional funding, it could potentially become a more vocal advocate for YIACS and help its members to develop their services, through additional research, training and toolkits.

For donors who are interested in supporting Scottish charities, **Young Scotland in Mind** is a good first port of call. A voluntary sector association with over 200 members, it helps to coordinate activities between charities working in different fields. These include children and youth charities as well as specialist mental health charities and community organisations, all of which have a common focus on children and young people's well-being. Young Scotland in Mind provides a forum for discussing sector issues and gives charities a stronger collective voice to highlight sector needs to government and the public.

Donors can choose to build the capacity of the sector or target their support towards specific issues, areas or groups.

Box 26: Identifying a good YIACS service

One particular problem for donors is the bewildering array of approaches to counselling and psychotherapy. At present, there is no accreditation scheme for youth counselling or therapy services. (NPC finds this surprising, considering there is quality assurance for less sensitive services, such as extracurricular activities.) As a result, commissioners and funders may shy away from funding a YIACS service due to lack of information about its effectiveness. At present Youth Access provides a quality standards manual for all member YIACS. However, it lacks the resources to monitor compliance, and has not been able to get funding to develop an accreditation scheme.

In NPC's view, donors should look for the following when assessing YIACS:

- good links with the local authority, and with local schools, GPs and other referring agencies;
- user participation (including young people involved in staff recruitment, planning, service design and delivery);
- good links with specialist CAMHS (ideally including: referrals in both directions; training; regular meetings; and mutual recognition);
- therapists who are registered with a professional body (such as the BACP, UKCP or COSCA) and receive regular supervision;
- careful selection, monitoring, and supervision of trainee therapists;
- appropriate procedures for safeguarding young people's well-being (eg, Criminal Records Bureau checks);
- procedures for routine and rigorous evaluation and analysis of results, and a culture of using results to review and develop services;
- a balanced trustee board with a mix of skills (eg, financial, legal, commercial, therapeutic, clinical, educational), perhaps including representatives from local government; and
- a business/strategic plan, a degree of financial stability, and a positive approach to dealing with changes in commissioning.

Another way of identifying good services is by asking what young people want, and then measuring the success of a service against this. Donors can look for charities that are involving young people in their services, consulting them about what they want and meeting their needs.

Invest more in infant mental health

Infancy is a critical period of development, which has a lasting impact on an individual's well-being. Infant mental health is a rapidly growing area of research, but as yet the charity sector is not developed. It offers an attractive opportunity for donors interested in research and early intervention to have a big impact on a developing field. However, donors will need to be aware that gathering evidence of results may take time.

The **Anna Freud Centre** is a good example of a charity working in this field, and the **Mental Health Foundation** plans to conduct research on infant mental health in the future. NPC intends to look at charities that work with infants in more detail as part of forthcoming research into caring for children.

Improve the evidence base

There are still significant gaps in our knowledge about what works, particularly when it comes to

promoting emotional well-being and resilience, and preventing the onset of mental health problems. Donors could invest in research being carried out in academic institutions or by charities such as the **Mental Health Foundation**, **YoungMinds** or the **Anna Freud Centre**. They should also support rigorous evaluation of services that charities run directly for children and young people, and encourage charities to share best practice, both with other charities and with the statutory and private sectors. For research priorities relating to specific conditions, donors can refer to Appendix 2 on NPC's website.

Develop the workforce

Improving the skills of teachers, youth workers, GPs, nurses and other frontline staff will help in two ways. First, it will mean that problems are identified at an early stage and referred on to specialists where appropriate. Second, it will relieve the pressure on specialist services by giving frontline staff the confidence to manage less severe problems themselves. There is also a strong case for investing in additional training for therapists and involving young people in their recruitment.

Donors might like to think about funding a charity that promotes professional development through training and consultancy. Training that brings together professionals from different backgrounds (for example, from psychiatry, education and social work) may help to improve the relationships between different agencies involved in supporting children and young people. Charities should be encouraged to involve young people in the development and delivery of training to ensure that their perspective is taken into account when services are developed.

Targeting your support

Sector priorities can sometimes seem overwhelming or intangible for donors who have limited means, or want to support individual children and young people more directly. There are many good charities in the sector who would benefit from funding that is targeted at local areas, specific issues, or vulnerable groups. Such charities may still contribute to the development of the sector. For example, by carefully evaluating the results of their services, they can help to build the evidence base.

Focusing on a local area

NPC's research suggests that local charities are vital to the sector. Donors could choose to focus on a particular area by funding a YIACS or similar organisation. YIACS are often a valuable component of local CAMHS provision and offer more immediate and accessible support than NHS counselling services, which tend to be

heavily oversubscribed. Youth work, such as structured group activities, can also promote good mental health, although the results can be harder to measure.

To find a YIACS in their area of interest, donors should visit the website of Youth Access, the national membership organisation for YIACS: www.youthaccess.org.uk. They should be aware that they will have to invest time up-front to get to grips with how effective a YIACS is, as there is no quality mark. The guidelines in Box 26 may help here. If the local YIACS in question is underdeveloped (which is often the case), the donor may also have to fund organisational development and be proactive in supporting the charity to improve management, funding, and evaluation.

Helping groups of vulnerable children and young people

Specific groups of children and young people are at greater risk of developing mental health problems, including child refugees and asylum seekers and children whose parents have mental health problems. By funding charities that provide targeted support for these groups, donors can help prevent problems turning into crises.

Donors might also like to target their support at charities that work with particular age groups, such as infants or 16–25 year olds. There are local opportunities to target vulnerable teenagers and young adults who are underserved by mental health services, for example through YIACS.

Tackling specific conditions or symptoms

Specific mental health disorders, such as eating disorders, OCD and anxiety, often require specialist help, which is why issue-focused charities such as **beat** and **Anxiety UK** are needed. These charities are often involved in research or training relating to these disorders, and provide direct support through helplines, self-help groups and information. Self-harm is a particular gap. NPC is not currently aware of any charity focusing on this problem at a national level, despite its prevalence. Substance abuse, which is both a product and a cause of mental health problems, will be covered in a future NPC report.

Tackling broader problems

Donors might also look beyond the sector to charities focusing on issues such as child abuse, domestic violence or truancy and exclusion, which are related to poor mental health. Problems such as bullying, low self-esteem and neglect are also known to be

associated with the development of mental health problems. Addressing these issues at an early stage will prevent bigger problems emerging.

Donors could fund charities that work with families, in schools or in the community. Some of these charities may target vulnerable children and young people through outreach or referral, while others may offer open access for anyone looking for help. School-based interventions such as those provided by **The Place2Be** and **Beatbullying** are an effective way of reaching large numbers of children and young people.

Raise awareness among parents and peers

Improving understanding of mental health among the public more broadly should improve the ability of family and friends to deal with problems at an early stage. Donors could fund charities that try to raise awareness through the media, such as **YoungMinds** or **beat**, or charities that run parent-training sessions or emotional literacy programmes in schools.

Improve access to help

Children and young people need support that is easy to access, confidential and available outside normal work or school hours. Donors may like to fund YIACS, which offer free drop-in services in town centre locations. Alternatively, they could fund helplines run by national charities like **Samaritans** or **ChildLine**, which provide 24/7 support, or helplines run by condition-specific charities such as **beat**.

Weighing the options

All the charities and issues listed above would benefit from additional funding. The decision about what to prioritise will therefore depend on the particular interests and preferences of the donor, as well as the size of their donation and the level of risk that they are willing to carry.

This is a sector that has lacked the resources to develop many strong organisations. So donors need to be aware that the most effective use of their funding may be to develop the organisation itself. This might include stabilising its finances, developing the staff team, or funding monitoring and evaluation. This is true of national charities as well as smaller local charities.

NPC has analysed in detail a selection of charities that improve children and young people's mental health (see www.philanthropycapital.org). These charities tend to need less organisational development than the rest of the sector, but offer only a limited range of options.

Raising public awareness of mental health issues should improve the ability of family and friends to deal with problems at an early stage.

For the donor who is willing to take a hands-on approach, funding a less developed or higher-risk charity could be rewarding.

For the donor who is willing to take a hands-on approach, funding a less-developed or higher-risk charity could be rewarding. NPC would recommend that donors invest time to assess the work of such charities and the level of funding that they have the capacity to absorb. Whilst a handful of charities have good outcomes data, in many cases donors will need to look at other factors when determining which charities to fund.

This is likely to be particularly important with local charities like YIACS, as discussed in Box 26. As local government funding is in flux, the finances of these charities are often unstable and donors would have to be comfortable with a high level of risk. They will also require patience—but committed funding for three or more years could be very valuable during this period of uncertainty, and help charities to continue providing important services to hundreds of local young people.

Ambitious donors might potentially consider building the sector's ability to fundraise from the general public by selecting larger charities that have an appetite for this type of fundraising. Alternatively, the sector might explore how it could tap into the fundraising ability of the big children's charities, such as the **NSPCC** and **Barnardo's**, to obtain more resources for improving children and young people's mental health.

Watch this space

There are some emerging opportunities in this sector that NPC would highlight to donors as potential options for future investment.

Although limited at present, collaboration between mental health charities and the national children's charities may be a fruitful area to explore over the next few years. In such a partnership, the mental health charity could bring specialist expertise, while the children's charity might have large volumes of 'clients'

vulnerable to mental health issues. There are some examples where partnerships are already developing. For instance, **Action for Children** (formerly NCH) and the **Prince's Trust** are consulting specialist mental health charities on the development of new projects on emotional well-being and mental health. However, beyond this, the appetite of the national children and youth charities in this area is largely untested.

The *Right Here* project recently launched by the **Mental Health Foundation** and **Paul Hamlyn Foundation** may generate further opportunities for donors who are interested in funding innovative approaches to improving children and young people's mental health. *Right Here* aims to address some of the structural problems in the sector by funding partnerships between voluntary and public sector organisations that test out new ways of preventing mental health problems in young people aged 16–25 years old. The pilot projects will be recruited from September 2008, with research commencing in 2009.

What next?

NPC can match donors with effective charities and talk them through how best to support them. We have an extensive library of over 140 recommended charities working across 22 areas of need. Details of current NPC charity recommendations can be downloaded from www.philanthropycapital.org.

NPC can also help donors who are interested in looking beyond these recommendations. Guidance on what we look for in effective charities can be found in *Funding success*, a report on NPC's methodology, which is currently being updated. We can also offer training in how to analyse charities and a bespoke charity analysis service for donors. For further information, please contact us at info@philanthropycapital.org or call us on 020 7785 6300.

Table 9: A snapshot of needs, evidence and charities

Government Responsibility	Need	Charitable Activity	Evidence of Effectiveness	Priority for Philanthropy
Child risks				
Genetics	The genetic causes of specific mental health disorders, and how to manage and treat them, are insufficiently understood. Research is needed.	Contributes to funding for medical research, eg, through hospitals, academic departments and Medical Research Council.	Limited involvement; charities working on this tend to be associated with academic departments, eg, Psychiatry Research Trust.	Possibly—likely to be of more interest to professional funders.
Resilience	More research into effective ways of developing skills that help children and young people to cope with stress is needed as this is a promising area.	Developing skills associated with resilience through programmes that work with parents and children, eg, <i>Sure Start</i> , <i>SEAL</i> and <i>PSHE</i> .	Good evidence about features associated with resilience but less about what works in practice.	Yes.
Learning disability; developmental disorders; chronic illness; and physical disability	Too little is known about the causes and risks, and what works in effective care and support for children and their families. Awareness of the mental health of these groups is poor.	Various. Refer to NPC's other reports: <i>Ordinary lives</i> , <i>A life less ordinary</i> , <i>Valuing short lives</i> and <i>Making sense of SEN</i> .	Mixed. See NPC's other reports.	Yes. Many opportunities.
Family risks				
Poor parenting	Many parents struggle to support their child's development in infancy and early childhood. They also struggle to manage emotions and behaviour.	Growing focus for government, eg, through <i>Sure Start</i> and National Academy for Parenting Practitioners.	Charities provide support for parents at home and in the community and run parent-training courses. More could be done on infancy.	Yes—especially hard-to-reach groups that may not be picked up by <i>Sure Start</i> .
Parental ill-health, eg, maternal physical health and parental mental health	Children of parents with mental health problems are twice as likely to experience a childhood psychiatric disorder: two million children are estimated to be affected. Children's future mental health is affected by ill-health/poor diet during pregnancy, and postnatal depression.	Falls into remit of adult mental health services and social services.	At a national level, Family Action's <i>Building Bridges</i> project supports children whose parents have mental health problems. Community charities are also active here on a more informal basis. Charities also provide information and support for postnatal depression.	Yes.
Child abuse; domestic violence; criminal activity	These issues can trigger the development of mental health disorders in children and young people. Tackling them early can prevent problems.	Various. Refer to NPC's reports on these issues: <i>Not seen and not heard</i> and <i>hard knock life</i> .	Wide range of charitable activity. See NPC's other reports.	Yes.

	Need	Government Responsibility	Charitable Activity	Evidence of Effectiveness	Priority for Philanthropy
Bereavement; trauma	Children who experience stress, trauma or loss are likely to be at higher risk of developing mental health problems. The right support can help mitigate this.	Only in so far as children and young people are referred to CAMHS or school counselling services.	Charities provide counselling and therapy, including a wide range of YIACS, The Place2Be, The Brandon Centre. Some charities have a specialism in trauma, eg, the Medical Foundation for the Care of Victims of Torture, or bereavement, eg, Winston's Wish.	Some charities have good data, eg, counselling and therapy charities like The Place2Be or The Brandon Centre. Generally the evidence base could be improved.	Yes.
School environment					
Peer pressure (to achieve, be popular, etc.), exam pressure	Support from sympathetic peers, teachers and school staff can help children and young people cope with pressures.	Initiatives to promote more positive and supportive school environments, eg, SEAL, PSHE, Targeted Mental Health in Schools. In Wales, counsellor in every secondary school.	Charities working to improve school culture and provide support for vulnerable children, eg, through confidence-building activities or counselling.	Good evidence for targeted support (eg, Place2Be) but much more limited for interventions that take a 'whole-school' approach.	Yes.
Bullying	Children with genetic susceptibility to mental health problems are five times more likely to develop severe problems if bullied. Other children are also affected. Tackling bullying in schools will reduce this risk.	No specific initiative, but promoting more supportive school environments, as above.	Several charities focusing on this area, eg, Beatbullying.	Good evidence.	Yes.
Community and peer group					
Poor local environments with nothing to do, contributing to gang culture	Children and young people need constructive activities, safe spaces and opportunities for play and exercise in order to develop mentally and physically.	Policy commitment through <i>Youth Matters</i> , but mainly implemented at local level.	Many community organisations are improving local areas.	Data is limited, but anecdotal evidence is compelling.	Yes.
Substance abuse	Substance abuse is closely associated with increased risk of mental health problems.	NPC to investigate in future.	NPC to investigate in future.	Unknown at this stage.	Likely.

Wider society					
Stigma and misunderstanding	Media and public attitudes and poor understanding of mental health problems inhibit families seeking help and inhibit early identification of problems.	Limited, though some support for specific campaigns, eg, anti-suicide campaign in Scotland.	Charities are looking at specific aspects, eg, Samaritans on the way suicide is represented, and beat on eating disorders.	Some international evidence for anti-stigma campaigns, but still early stages in the UK. Changes in public attitudes can be difficult to achieve and measure. NPC's report <i>Critical masses</i> examines the impact of public campaigning.	Yes.
Unhealthy lifestyles	Lack of exercise and poor diet can contribute to the development of mental health problems.	Promoting healthy lifestyles through a wide variety of initiatives, including the <i>National Healthy Schools</i> programme.	Charities are involved in research around links between diet and poor mental health.	Limited evidence specifically on mental health benefits. This is a growing area of research, but not yet mainstream.	No – because a focus for government.
Treatment and recovery					
Treating existing mental health disorders and supporting recovery	Treating children early improves the chances of recovery, yet over 40% of children with mental health problems do not have contact with a professional.	CAMHS and AMHS should provide treatment, but waiting lists are long and only 25% of children with a diagnosed problem have consistent access to services over three years.	Charities, eg, YIACS, provide talking therapies and practical and emotional support to ensure that children and young people receive good care and are helped on the path to recovery.	See Table 4 in Chapter 2. Good evidence for certain therapies but still significant gaps in our knowledge.	Yes.
Sector improvement					
Strengthening the structure and profile of the sector, the capacity of the workforce, and changing policy	Children and young people's mental health needs to be moved further up the government's agenda. Charities need strengthening to push this.	Funding for government services is insufficient. There is no champion in central government. Coordination between local agencies could be improved.	Charities should be able to help here but the national campaigning charities are comparatively low profile.	Evidence for small-scale successes, eg, changes to the <i>Mental Health Act</i> . Little evidence for broader sector progress, but should be possible to improve. Other sectors have demonstrated their impact effectively, eg, disabled children and palliative care sectors.	Yes – but challenging.

Final word

Children and young people's mental health is everybody's business. Good mental health enables children to overcome adversity and grow up into adults who can enjoy life and make a positive contribution to society. Mental ill-health is associated with some of the most pressing and costly social problems, including truancy, crime, homelessness, domestic violence and suicide.

A wide range of charities are involved in improving children and young people's mental health from a variety of different angles—from improving the ability of parents to nurture their

child's development, to campaigning for better inpatient care for teenagers with psychiatric disorders. But not all these charities would necessarily define themselves as part of a children's mental health sector. This means that donors need to keep an open mind and weigh up all the funding options. Whatever issue they choose to support, additional funding is likely to be desperately needed. Charities that promote children and young people's mental health offer exciting opportunities to make a big difference to a vital sector.



Photograph supplied by Youth Access



Photograph supplied by Chance UK

Glossary

Active listening: A way of listening that focuses entirely on what the other person is saying and confirms understanding of both the content of the message and the emotions and feelings underlying the message to ensure that understanding is accurate.⁹⁶

Anorexia nervosa: An eating disorder that makes people very anxious about their body shape and weight. They try to control it by dieting, vomiting or exercising excessively. How they see themselves is often at odds with how others perceive them, so they continue to want to lose weight even when they are very thin. Anorexia can cause severe physical problems including loss of muscle strength, reduced bone strength, and interrupted menstruation in women and girls. Men can suffer from a lack of interest in sex or impotency. It can also affect the quality of relationships with family and friends, and performance at school or in the workplace. Anorexia most commonly starts in the mid-teens and, in teenagers and young adults, affects about one in 250 females and one in 2000 males.^{31, 187}

Anxiety: There are several conditions for which anxiety is the main symptom, including phobias and post-traumatic stress disorder. However, generalised anxiety disorder (GAD) is a long-term condition that makes people feel anxious about a wide range of situations and issues and inhibits their ability to perform everyday tasks. It can cause both psychological and physical symptoms. GAD affects approximately one in 50 people at some point during their lifetime and the disorder is most common among people in their early 20s.³¹

Attention-deficit hyperactivity disorder (ADHD): A medical condition, also sometimes known as attention-deficit disorder (ADD), that should not be confused with normal excitable or boisterous childhood behaviour. Symptoms usually start around the age of four and may include: poor concentration; restless and disruptive behaviour; difficulty in following instructions; and little or no sense of danger. It is the most common behavioural disorder that starts in childhood and affects 5% of children and 2–4% of adults. Experts think it is caused by an imbalance of neurotransmitters that makes it difficult for the brain to process all the information and stimulation that it receives. ADHD can run in families.³¹

Body dysmorphic disorder (BDD): A condition that is characterised by extreme anxiety over body or appearance. It has similarities with Obsessive Compulsive Disorder.³¹

Bipolar disorder: A condition also known as manic depression. It is an illness that affects mood, causing a person to switch between feeling very low (depression) and very high (mania).⁹⁶ In contrast to simple mood swings, each extreme episode may last for several weeks or longer. Although the exact cause of bipolar disorder is not fully understood, the condition seems to run in families. Approximately one person in 100 is diagnosed as having bipolar disorder. It can occur at any age but it often develops between the ages of 18 and 24.³¹

Bulimia nervosa: An eating disorder characterised by a cycle of binge eating followed by purging (by self-induced vomiting or taking laxatives and diuretics) or excessive exercising and fasting. As with anorexia nervosa, people evaluate themselves in terms of their body shape and weight. They usually hide this behaviour from others and their weight is often normal. Symptoms can include mood swings, low self-esteem, anxiety, self-harm, tiredness, constipation, irregular periods, feelings of bloating, and occasional swelling of the hands and feet. Excessive vomiting can cause problems with the teeth and laxative misuse can seriously affect the heart. Approximately eight in every 100 women will have bulimia at some point in their lives and the condition often develops around the age of 19. It is rarely found in children.^{31, 187}

Cognitive behavioural therapy (CBT): A term that covers a range of therapies that are designed to solve problems in people's lives, such as anxiety, depression, substance abuse, or post-traumatic stress disorder (PTSD). It works on the premise that in order to address these problems, people need to change both the way they think and the way they behave at the same time. CBT is more structured and pragmatic than most other forms of psychotherapy. For example, the therapist and their client will work together to identify a specific problem, break it down into smaller parts and then set goals to work towards. This may include homework in the form of activities to try or techniques to use before the next therapy session. CBT is more focused on the present, whereas some other therapies concentrate on exploring and resolving past issues.⁹

Conduct disorders: These disorders are characterised by severe and persistent disobedience and defiance. Typical behaviour includes unusually frequent and severe temper tantrums beyond the age that this is normally seen, excessive levels of fighting and bullying, cruelty to others or animals, running away from home and criminal behaviour.³²

Counselling: Counsellors see a client in a private and confidential environment to explore a difficulty the client is having or distress they may be experiencing. By listening attentively and patiently and allowing open discussion of the client's feelings and thoughts, the counsellor can start to understand their point of view and help them to see things more clearly. Counselling is non-judgemental and does not involve directing a client to take a particular course of action.¹⁸⁸

Depression: A mental health disorder characterised by depressed mood, loss of interest and enjoyment, and reduced energy that leads to increased tiredness, often after minimal effort. Other symptoms include: reduced concentration and attention; reduced self-esteem and self-confidence; pessimistic views of the future; ideas or acts of self-harm or suicide; disturbed sleep; and diminished appetite.⁹⁶

Early Intervention in Psychosis Teams: Teams of specialists from government mental health services who work with 14–35 year olds who have experienced their first episode of psychosis. People are often at greatest risk of causing harm, both to themselves and to others, during the years following their first episode. The teams therefore focus on the early identification and assessment of psychotic symptoms and provide support and counselling to help treat the underlying causes.^{11, 31}

Eye Movement Desensitisation and Reprocessing (EMDR): A form of treatment for post-traumatic stress disorder. EMDR involves focusing on a particular physical action while thinking about traumatic experiences in order to change the individual's thoughts and feelings about those experiences.¹⁰⁰

Family therapy: This involves a therapist working with a family to find constructive ways to help each other. Family therapy can be used to address a wide range of issues including: the mental health problems of family members; parenting; couple relationships; domestic violence; substance abuse; and stressful events such as separation, divorce, bereavement or trauma. It is often referred to as systemic family therapy. Although family therapists usually work with family groups, they may also do one-on-one work with individuals and, where appropriate, may work with the professional and social networks around families.^{100, 189}

Interpersonal therapy: A short-term form of psychological therapy that focuses on a specified range of 'interpersonal' (ie, relationship-based) problems that may underlie an individual's depressive disorder. It was originally developed for depression in adults but has been adapted to treat depression in adolescents and bulimia nervosa.^{49, 190}

Mental Health Trusts: Mental health services are organised by specialist Mental Health Trusts in many parts of the country. They provide inpatient care, residential care centres, day clinics, drop-in centres, and community and rehabilitation services. There are currently over 40 Mental Health Trusts in England and Wales.¹⁹¹

Motivational interviewing: A form of counselling that helps patients to weigh up the advantages and disadvantages of changing their behaviour. The counsellor uses reflective listening to show empathy and convey understanding of the patient's perspective and motivation, helps the patient to explore the discrepancy between his or her values and current behaviour, and builds their confidence that change is possible.¹⁹²

Multi-modal therapy/programmes: Treatment programmes that use techniques from various different theoretical perspectives. For example, in the treatment of ADHD, psychotherapy may be combined with parent-management training, self-instructional training for the child or young person, and stimulant medication.⁸⁸

Multisystemic therapy (MST): A programme that helps young people with severe conduct problems by targeting the issues that influence their behaviour—at home, at school and in the community. It draws on a range of therapeutic approaches and involves working closely with families for three to five months to improve communication, introduce systematic reward and punishment systems, and address day-to-day conflicts. MST practitioners visit the family home two or three times a week for at least three months and liaise with schools and other agencies such as social workers, youth offending teams and CAMHS. Young people are encouraged to spend time with peers who do not have problems and to take part in positive, structured activities.³⁴

Nocturnal enuresis (bedwetting): Bedwetting while asleep is very common in children, particularly those under the age of six or seven: approximately one in seven five year olds and one in twenty ten year olds wets the bed. It is more common in boys than girls, and is sometimes a sign that a child is upset about something.³¹

Obsessive compulsive disorder (OCD): A common mental health condition that affects 2% of the population. It is characterised by obsessive thoughts that cause anxiety and lead to rituals or repetitive actions such as excessive hand-washing or neatness. An inability to complete the compulsion tends to result in severe anxiety or panic.³¹

Oppositional defiant disorder (ODD): A disorder defined by serious defiant, disruptive and hostile behaviour, often directed against authority figures such as parents and teachers. It is common among children with ADHD.^{31, 88}

Parent training: Programmes developed to help parents (or other carers) improve their relationship with their child and improve their child's behaviour. Some involve the children and young people as well, while others do not. NICE recommends their use for the treatment of children and young people with conduct disorders and ADHD. Programmes tend to be structured and short-term. They may be run by psychologists, therapists or counsellors, social workers or community workers. Some can also be run from the home using printed or audiovisual training tools.¹⁰¹

Personal Social and Health Education (PSHE): PSHE covers topics including sex and relationship education, drug education, careers guidance, parenting and financial literacy. Schools are given the freedom to tailor their programme to meet the age range and cultural background of their pupils.

Person-centred therapy: An approach to counselling and psychotherapy that works on the premise that the relationship between the therapist and the client is of primary importance. It is based on respect for the client and encourages them to think of themselves as 'the experts in their lives' and to take responsibility for their own development, by exploring their experiences, emotions, strengths and difficulties in a non-judgmental therapeutic relationship.¹⁹³

Phobia: A constant, extreme or irrational fear of an object, animal, place or situation that would not normally worry the majority of people.³¹

Postnatal depression (PND): Sustained periods of depression that occur in new mothers. It affects approximately one in ten mothers in the UK and usually develops in the first four to six weeks after childbirth. Postnatal psychosis is a rare, but severe, form of depression that occurs in about one in 1,000 mothers. Symptoms may include irrational behaviour, confusion, and suicidal thoughts, and women with postnatal psychosis often need specialist psychiatric treatment.³¹

Post-traumatic stress disorder (PTSD): A term that is used to describe a range of psychological and physical symptoms that people may experience following a traumatic event. Symptoms may include vivid flashbacks, intrusive thoughts and images, nightmares and distress at reminders of the trauma. PTSD develops in up to one third of people who have experienced a traumatic event and it may affect approximately 8% of people at some point in their lives. It can occur in people of any age, including children.^{194, 195}

Primary Care Trusts (PCTs): PCTs manage primary health care in England, working with local authorities and other agencies to ensure that the needs of the local community are met and services are well coordinated. There are about 152 PCTs in England, each covering a separate area. Together they control approximately 80% of the NHS budget, which is equivalent to approximately £58bn.¹⁹⁶⁻¹⁹⁸

Psychoanalytic/psychodynamic psychotherapy: Psychological therapies that explore unconscious processes and past relationships to gain insight into the causes of current behaviour, conflicts and modes of thought. Therapy is non-directive and recipients are not taught specific skills (such as thought monitoring, re-evaluating, or problem solving).^{96, 100} Psychotherapy lasts for months or sometimes years. It may be carried out on an individual basis or as part of a group.³¹

Psychological therapies: A collective term for treatment methods that involve psychosocial rather than physical intervention. These include cognitive behavioural therapy, family therapy, psychodynamic psychotherapy, group psychotherapy, counselling, art therapy, interpersonal therapy, person-centred therapy, guided self-help and any other form of treatment that aims to be helpful through the communication of thoughts and feelings in the presence of a therapist, who uses a systemic framework for understanding and responding to them.⁹⁶

Psychosis: A symptom of medical conditions where somebody is unable to distinguish between reality and their imagination. People with psychosis may experience hallucinations or delusions. The most common causes of psychosis are mental health disorders such as schizophrenia and bipolar disorder. It can also be caused by physical conditions such as Parkinson's disease, or by substance abuse. Approximately one in 200 people in the UK has experienced psychosis.³¹

Randomised controlled trial (RCT): An experiment in which investigators randomly allocate eligible people into groups to receive or not to receive one or more interventions that are being compared. The results are assessed by comparing outcomes in the different groups. Through randomisation, the groups should be similar in all aspects apart from the treatment they receive during the study.⁹⁶

Self-harm: Not strictly a disorder in itself, but often the symptom of an underlying mental health problem. It is the way some young people deal with psychological distress. It can include cutting, burning, or poisoning oneself, and taking overdoses. Young people aged 15–24 are many times more likely to be involved in self-harming behaviour than any other age group.³

Schizophrenia: A chronic mental illness that causes symptoms including hallucinations and delusions (known as psychotic symptoms). The exact cause of schizophrenia is not fully understood, but experts believe that it is caused by a combination of genetic and environmental factors. The onset of schizophrenia is usually between the ages of 15 and 30 for men, and between 25 and 30 for women. Approximately one in 100 people will experience at least one episode of acute schizophrenia during their lifetime.³¹

Social and Emotional Aspects of Learning (SEAL): A curriculum resource for primary and secondary schools, which is designed to improve social and communication skills, self-awareness, motivation, empathy and emotional well-being. SEAL aims to work with the whole school, for example through school assemblies, and provides materials for specific activities during and outside lesson time. It also offers staff development opportunities, and should ideally be integrated with a school's PSHE programme.

Tier 1 CAMHS: Primary care services including GPs, paediatricians, health visitors, school nurses, social workers, teachers, juvenile justice workers, voluntary agencies and social services.

Tier 2 CAMHS: Services provided by professionals relating to workers in primary care including clinical child psychologists, paediatricians with specialist training in mental health, educational psychologists, child and adolescent psychiatrists, child and adolescent psychotherapists, counsellors, community nurses/nurse specialists, family therapists, and art, music and drama therapists.

Tier 3 CAMHS: Specialised services for more severe, complex or persistent disorders provided by child and adolescent psychiatrists, clinical child psychologists, nurses (community or inpatient), child and adolescent psychotherapists, occupational therapists, speech and language therapists, art, music and drama therapists, and family therapists.

Tier 4 CAMHS: Services such as day units, highly specialist outpatient teams and inpatient units.⁹⁶

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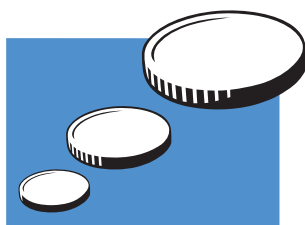
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