‘Getting it right, first time’
Prevention of Mental Illness

A report by West Midlands Academic Health Science Network
Presented to the Mental Health System Strategy Board
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Executive Summary

In March 2015, the Government launched Future in Mind announcing a strategy and plans for improved mental health support for younger people and revealing the huge impact of problems with mental wellbeing in early years. The figures showed that young people are affected disproportionately, with over half of mental health problems starting by the age of 14 and 75% by 18. In January 2017, the Government announced further plans to “transform” attitudes to mental health, with a focus on children and young people, reminding us that one in four people has a mental disorder at some point in their life, with an annual cost of £105bn - similar to the entire annual NHS budget.

There is clearly an urgent need for action, and overwhelming support for a more integrated approach. There is also increasing evidence for the success of prevention and early intervention strategies. This is an unprecedented opportunity to make big improvements to the mental health of our society, by ‘getting it right, first time’.

But with limited resources and a need for widespread adoption, it's essential that we identify a model of mental health care that is measurable, effective, scalable and achievable. This report has been produced for the Mental Health System Strategy Board by the West Midlands Academic Health Science Network (WMAHSN) supported by Forward Thinking Birmingham, to assess the prevention priorities for Birmingham and Solihull (and potentially the region) and set out the next steps. In it, we summarise world-leading research into the prevention and early intervention of mental illness, and distil the evidence in order to identify approaches that we believe can be implemented effectively.

It is vital that we prove the effectiveness of these approaches to develop a far-reaching system that is collaborative, sustainable and effective. Therefore, our key recommendation is for the Mental Health System Strategy Board to support a ‘proof of concept’ programme. The strategic approach can be depicted as follows:
This will encompass the Forward Thinking Birmingham (FTB) and Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) models, and involve partners across health and social care, education and policing. In addition, it will collaborate with community resources to provide low-stigma, engaging support from within a community setting, and build on current partnerships for training and interventions within school settings. The programme will also focus on improving the reflective capacity and engagement of relevant professionals by implementing Psychologically Informed Environments (PIE) or similar approaches in workplaces.

This proposed programme will be designed to provide the evidence required to develop an improved, integrated mental health system, so that the Mental Health System Strategy Board can be confident that it will accelerate real change and improvements. In this way, we can take great steps towards our goal of sharing these learnings and ways of working across the West Midlands, to benefit the wider population of 5 million people.

The Mental Health System Strategy Board made the prevention of mental ill-health a priority for the region and we look forward to collaborating with you in implementing this strategy.

I wish to thank Dr Paul Patterson, FTB and Neil Mortimer, WMAHSN for their expertise, dedication and their immense contribution to the completion of this document.

Dr Peter Lewis
WMAHSN Clinical Lead for Mental Health
Introduction

‘Prevention of Mental Illness’ is an aim that would have seemed remarkably aspirational even five years ago. However, in recent years there have been clear convergences from neurological, public health, economic and social psychiatry research that all demonstrate common causal and risk factors for mental illness.

We now know a great deal about the role of childhood adversity in sensitising the brain to chronic stress and sowing the seeds of pathological anxiety and mood responses - sources of many mental disorders. Knowing that we can clearly identify the factors that are driving 30% of mental disorders - as well as probably many of our public health priorities - allow us to target accordingly.

There are many practical questions to consider:

- Which age range should we focus on?
- What are the model parameters?
- Do we have enough staff with the right skills and expertise?
- How do we involve users?
- How will partnerships work?
- What are the local needs and funding priorities?

To provide answers, WMAHSN has completed this ‘prevention of mental illness’ review and developed an outline strategic plan.
Project Methodology & Activity (July 2016 - February 2017)

The Mental Health System Strategy Board commissioned the West Midlands Academic Health Science Network (WMAHSN) to identify a strategic approach to the prevention of mental illness.

WMAHSN is licensed by NHS England to drive and support the adoption of innovation at scale and pace. As a collaboration between NHS and care organisations, academia, business and citizens, it has the double aim of improving health and delivering economic value to the region. One of WMAHSN’s four key priorities is Mental Health, with an emphasis on crisis, prevention and recovery. While the WMAHSN remit is region-wide, this is an opportunity to capitalise on the partnership working already underway in Birmingham & Solihull.

This report has been developed with support from Forward Thinking Birmingham, and is underpinned by two key principles:

**Co-design and co-production**

All relevant stakeholders including commissioners, providers (current and potential), service users and carers should be actively involved in planning, developing, implementing and evaluating services.

**Sustainability**

In planning, delivering and evaluating the effectiveness of services, consideration should be given to the long-term sustainability of services. In addition to identifying resources to prove these models, consideration should be given from the outset about how they may be commissioned as mainstream services once proven.

Project activities were as follows:

**Formed project board, defined ‘Prevention’ and project scope**

There was great enthusiasm from professionals who were keen to be involved and there was a wide range of activities, information and responses to be collated and explored, in a tight timescale.

**Rapid review of research policy and report literature on prevention of mental illness**

A rapid review of current research confirmed that youth and adolescence was the main high-risk period for many emerging mental illness conditions but that causal factors were generally related to much earlier events and experiences. An
increasing body of evidence suggests that early years’ support, education and training; parental attachment practices, and early identification and support to reduce perinatal mental ill-health would be the most promising initial targets for identification of those at high-risk and the instigation of prevention strategies.

There is ongoing research into the wider implications of epigenetics and DNA methylation, chronic stress and attachment for inherited and acquired early risk vulnerabilities, but there appears to be general consensus that early trauma and childhood adversity is perhaps the single most important target to address for a prevention strategy. With increasing research into early years, parenting and attachment-based support programmes there is an increasing pool of potentially effective interventions to consider in this area - with some already active in the Birmingham region. We have therefore suggested a focus on early years as our initial recommendation and provide a further summary of evidence in the appendices.

There is a large and disparate range of literature on the suitability of schools as appropriate focal points for risk identification and targeted interventions. However, evidence appears to favour ‘whole school’ approaches that combine a universal supportive ethos promoting wellbeing and resilience alongside targeted risk identification and intervention strategies for those most vulnerable. Birmingham has recently benefited from two years of intensive research and evaluation of interventions in local schools resulting from the Big Lottery funded ‘Headstart’ programme. This has allowed for a relatively quick identification of appropriate intervention methods building on this foundation work. A digital strategy, which encompasses a number of our recommendations is particularly important in any schools-focused work. Schools are our second recommendation for any future prevention working with a further summary of evidence in the appendices.

Digital tools and resources are currently under-utilised by most current service models, but could be used to support, inform, assist and revolutionise methods and practices in relation to health, risk-identification, awareness raising, therapeutic interventions and training. There are many innovative digital providers in the local region that could support both overarching and targeted education, resource development and targeted interventions - especially for the high-risk and ‘hard to reach’ groups that often do not engage with traditional service models. We have provided a further overview in the appendices.
Local provision mapping review of all Birmingham services involved in relevant prevention activities
Service providers, particularly in mental health, are currently experiencing rapid change and re-development in England. This is due to a recent Government policy focus, the sustainability transformation plans (STPs) and Future in Mind recommendations that all prioritise ‘Prevention’. We have explored models of innovative service provision in an overview in the appendices but are locally well placed to benefit from the recent service changes and evolving partnerships to youth mental health provision in Birmingham which emphasise prevention and early intervention. If service developments can maintain momentum and continue to build close collaborations with other system providers in the local region there is a real opportunity for the region to take a lead role in demonstrating the potential for prevention in the current climate. A further overview is provided in the appendices.

Best practice review of interventions & services provided regionally, nationally and internationally - assessed for impact and efficacy
The project completed a full mapping review of all services in the Birmingham region providing interventions, activities or training that were relevant to the prevention theme and a table is provided in the appendices. We assessed local services for the provision of evidence-based interventions and these intervention providers are highlighted in the early years and schools intervention appendices.

Hosted two prevention Seminars with leading professional presentations and discussions of evidence; plans in place (April, May) for further seminars focusing on young people and including input from the digital/commercial sector
A seminar on prevention in youth mental health was held at the University of Birmingham with 12 speakers - including world experts on youth mental health, a young service user and leaders in youth mental health service design in England. It attracted an audience of approximately 85 participants who engaged in debate and feedback. There was a consistent theme across the presentations, that a new model needed to include improved risk identification, early targeted interventions, education, self-help and awareness-raising alongside full stakeholder participation and professional outcome evaluation.

A second seminar in Leamington Spa involved four senior health leaders and researchers presenting their research in prevention of mental illness to approximately 50 participants. This was followed with planning workshops where it was agreed that
a trial was warranted to allow for comprehensive assessment, evaluation and scaling up of a future prevention strategy.

Interviews with key Birmingham senior service leads and integration of responses to major themes with focus on Birmingham’s current strategic priorities and direction and Interim Report - January 2017

From this work an interim report with key recommendation themes was generated and circulated to local commissioners and senior service providers. Following this the key themes were ‘sense checked’ by some individual interviews with senior managers from key organisations and with feedback from young service users. The responses consistently supported the recommended themes and agreed that a trial to test the efficacy of a model combining the recommendations was the next logical stage. This was integrated into the current report and further feedback from the seminars and stakeholders is included in the appendices section.
Prevention - key recommendations

1. Focus on Early Years (perinatal / parent & child /attachment / school readiness)

**Why?** There is robust evidence from the research literature and recent reports that the most productive and cost-effective element of any prevention of mental ill-health strategy will be during a child’s early years. Reducing the experience and impact of adversity in childhood and building support and interventions for early years parenting, perinatal needs and in school, provides the greatest opportunities for improving long-term outcomes.

**How?** Building on already existing programmes of work and developing a comprehensive training platform for staff. An early identification and intervention programme for those most at-risk with appropriate validated interventions and monitoring. This will require active partnership and multi-agency working to make most effective use of available resources and support. For Birmingham, this will involve working closely with already established partnerships to ensure best use of resources and sharing of expertise to build a lasting programme of work.

**Proof of concept** - Test the efficacy of agreed intervention strategy in an integrated multifaceted trial of concept.

**Intended Outcomes** - increased awareness and understanding of impact of childhood adversity and importance of attachment and resilience building amongst professional staff and carers/parents; increased number of staff and carers / parents trained and informed by increased school readiness of local young people; improved identification and support of perinatal risk.

**Potential partners and interventions** - Described in Evidence section.

**Evidence review** - Appendix A Early Years.

2. Work with Schools and Education to identify vulnerabilities and risk markers for mental illness and build preventative resilience and wellbeing practices in a whole school ethos

**Why?** Schools, colleges and universities are essential components of any preventative response for youth mental health. Evidence confirms that the most mental illness first emerges during the school years, and it’s still the case that the majority of individual cases of mental ill-health are not identified nor offered appropriate treatment at the time. It follows that there is a clear rationale to develop prevention strategies that involve
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education settings as core elements. Most young people who are at the key risk age for emerging mental illness will already be attending schools and colleges, so prevention programmes must collaborate with educational establishments to enable a successful risk identification and early intervention strategy to succeed.

How? Schools in Birmingham have recently benefited from a two-year pilot project on best practice for preventing mental illness and increasing resilience and wellbeing in schools. Funded by the Big Lottery, the Birmingham Headstart programme generated an inter-agency partnership to develop mental health and wellbeing strategies for schools in Birmingham. It also reviewed best practice in the field. This partnership is still active and working closely with the Birmingham Education Partnership, serving as the strategic board for preventing mental illness in schools. Building on this existing partnership we have identified current innovative practice in Birmingham such as the ‘Newstart’ academic resilience programme that could serve as hubs to build more complete prevention strategies in the region.

Proof of concept - Test the efficacy of agreed intervention strategy in an integrated multifaceted trial of concept.

Intended Outcomes - Early identification and intervention with those at risk of mental health difficulties; reduce school exclusions, improve knowledge understanding and ‘academic resilience’.

Potential partners and interventions - Described in evidence section.

Evidence review - Appendix B Schools and Education.

3. Employ Digital & Social Media Tools cross all (Universal) community / organisational / educational and public groups to raise awareness, promote self-help and resilience building strategies, reduce stigma and encourage sharing of best practice.

Why? Digital resources, tools and interventions are an essential element of any proposed strategy that focuses on mental health particularly for prevention and early intervention approaches.

How? Digital covers two interrelated areas:

   i) Information, evidence, training and best practice networks via an online hub
   ii) Developing digital resources and intervention tools to build resilience and prevent mental illness

These can be used across all (Universal) community / organisational / educational and public groups to raise awareness, promote self-help and resilience building strategies, reduce stigma
and encourage sharing of best practice. Building robust partnerships with the local digital industry and social enterprise we can design and pilot innovative solutions to support mental health resilience building and wellbeing.

We propose the need for cross-agency funding to support a single point of access website. This will act as a ‘front door’ for all key service mapping, training and the promotion of educational events in Birmingham. Updates should be managed by a small funded ‘digital navigation’ team - working alongside agencies to integrate and support best use of local digital services and information. For example:

- Build on the web based digital platform, YouthSpace and SchoolSpace created by the Birmingham Youth Board in collaboration with BSMHFT, Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and WMAHSN
- Involve commercial organisations with specialist expertise in digital innovation to deliver benefits quickly and cost-effectively. Hold digitally-focused prevention seminars to outline the prevention strategy to the commercial digital sector and encourage the development of novel and cost-effective technologies that enhance programme delivery and improve outcomes. This can be enhanced using the innovation accelerator programmes already developed by WMAHSN.
- Include Social Prescribing as a key element of a community focused digital prevention strategy - building on the local pilot work of clinicians at the Karis centre.

Proof of concept - Test the efficacy of agreed intervention strategy in an integrated multifaceted trial of concept.

Intended Outcomes - Share evidence and information; promote prevention programme; host online training via webinar / podcasts / TEDx & elearning; reduce exclusions, reduce mental illness/problems (e.g. eating disorders)

Potential partners and intervention - Digital industry; PocZero; NHS; BEP (Emotional & wellbeing board)

Evidence review: Appendix C digital technology

4. Identify or establish an integrated partnership approach across mental health service providers, sectors, professions and organisations. Develop youth mental health services that focus on prevention / education / early identification.

Why? The proposed prevention programme will need to work with local services that are already providing prevention and early intervention to ensure there is a consistent and robust care pathway in place. In a previous review we explored models of youth mental
health service provision and best practice, including key elements of the current partnership model for young people (0-25) in Birmingham - and the BSMHFT 0-17 Solar programme in Solihull. The existing and developing local partnerships with all key statutory and third sector agencies appear to be appropriate and sustainable models to build a sustainable programme for prevention of mental illness.

How? This is already active and evolving. We will focus on innovative community engagement that actively works in partnership with young people as a core function of the new service. This builds on the PAUSE community drop-in and engagement model, Early Years and vulnerable groups interventions alongside a commitment to high-quality training expertise and partnership working. Learning from these programs about what works should be supported in the prevention strategy and must form part of the integrated services in the in proof of concept sites.

Intended Outcomes - Seamless care, economies of scale/avoid cost duplication, shared risk & reward

Potential partners - FTB, BSMHFT, Third Sector Partners

Evidence Review: Appendix D models of youth mental health
Essential Overarching Proposals

5. Establish a Mental Health Prevention Partnership Board to oversee implementation and evaluation of the business plan emerging from the prevention strategy.

Why? The Board can ensure that the prevention strategy is coordinated alongside plans for the Under 25's Transformation Plans Refresh 2016/17 and helps to influence the emerging STP strategy.

6. Establish appropriate 'Champions' with policy influence to support effective strategies and establish new practice

Why? Positive change management involving innovative practices requires dedicated support from influential system leaders who are committed to both the need for change and strategies for enabling change.

How? Many individuals have already demonstrated that they are passionate about such joined-up thinking and strategies but often are already overburdened and committed. We propose that Birmingham hosts a TEDx Talk event on mental health prevention, as a motivational ‘kick-starter’ for the strategy. Led by national prevention experts, this event will bring together local champions and can be filmed to deliver further engagement post-event.

Intended Outcomes - Ownership across all agencies
Potential outcome - Formation of a high-level ‘Prevention of Mental Illness' Board with senior representation from Birmingham’s major stakeholders in relevant organisations.

7. Build a bespoke professional and engaging training programme to build a common understanding of the importance of prevention and early intervention.

Why? Having a collective understanding of the importance and potential of a prevention of mental illness model is a prerequisite for a shared vision and good quality inter-agency working.

How? Develop a robust training programme that integrates the latest findings on the impact of adversity in childhood and evidence from effective early intervention. This can include resilience building methods and resources for all staff and carers working with or caring for young people. Maximising the efficiency of this approach, we would recommend combining this training with a dedicated reflective practice model for individual reflection and insight. This could be similar to the PIE programme that has been established in Birmingham by St Basil’s. Developing this as part of a pilot strategy, we can build a solid foundation of awareness and knowledge in specific regions and closely monitor and evaluate the impact for later roll-out. Accreditation could be sought through partnership with
a local academic institution.

8. Identify selected populations in Birmingham and Solihull to establish Proof of concept or demonstrator sites.

How? We need to implement these recommendations in an integrated way over a sufficient timeframe for valid interpretation of impact and value. This will not preclude components of the prevention strategy, currently being delivered or subsequently developed, from being implemented or continuing in other areas of the city.

See section - Birmingham Demonstrator Site - Outline Proposal
Stakeholder Involvement

Prevention seminars

WMAHSN and FTB has hosted two professional seminars on the theme of Prevention of Mental Illness in the West Midlands region, providing an overview and summary of recent evidence and understanding from the relevant fields in applied and academic research and evaluation. Some of the key themes that emerged from these events with collective agreement included:

- Increasingly important to adopt prevention as a core element of service rationale and function.
- The growing evidence for the impact of early adversity on mental health and potential for therapeutic impact provided a strong rationale for investing in training and effective risk identification and intervention in early years.
- Identification of those at ‘high-risk’ of developing mental illness was regarded as potentially the most efficient strategy to employ to enable effective targeted early intervention programmes.
- User participation in service design was regarded as an essential element of good practice in provision.
- Transition points in services, in schools and developmentally are natural periods of heightened risk for recognition of vulnerability to mental ill-health and should be regarded as priority targets for risk identification and intervention.
- Policy has been moving in the direction of prevention and early intervention in recent years but there were relatively few models of service design that were integrating the recommendations of these policies in a robust way.
- The evidence and potential for prevention approaches across many high-risk populations and for many mental health conditions was salient, yet this evidence was still in the early days of being translated into actual practice.
- The potential for digital technology to enable additional effective strategies and solutions across education, training and therapeutic intervention and evaluation is vast and growing - yet barely acknowledged in mental health service provision to date.

Interviews and User Feedback

We conducted additional interviews with senior service managers in the city and asked a sample of young people to reflect and respond to the initial results of the literature review and recommendations for prevention. The responses were consistently positive about the initial recommendations. They also provided additional direction and recommendations especially in relation to the necessity for high quality training of all staff on the impact of
childhood adversity and the urgent need of a consistent multi-agency approach to addressing this theme for greatest impact and return on investment. Some of the key recommendations that emerged from these interviews included:

- Training was regarded as a basic element of any successful programme going forward. It was emphasised that this required a collective approach and the development of a comprehensive foundation level training programme that included the latest research findings and that could be delivered to all key staff and support services involved in working with young people, families and vulnerable groups.

- Effective partnership working and good communications were universally regarded as vital to any prevention strategy. This included clarity of each organisation’s roles and agreement for working to the same protocols. To aid effective understanding of working practices, information sharing protocols and a universal platform for sharing information across health and social care organisations were recommended.

- There was also collective agreement on the need for a cross-agency high level Prevention Partnership Board that would have the authority and flexibility to make informed decisions to partnership working in relation to the organisation of intervention strategies and effective programmes of work in the field.

- Several managers referred to the potential for digital tools, resources and education to increase efficacy and reach of services and acknowledged that this was still in the very early stages of being explored in relation to the prevention theme. There were references to several local innovative programmes of work that could be utilised to good effect in any prevention programme.

- Many of the managers described the need to integrate better engagement practices to ensure diverse and vulnerable groups were fully integrated into a prevention strategy - particularly as these groups are often associated with higher risk of mental health difficulties. Digital technology was described by several as having great potential for supporting this element of any programme.

- Many of the managers reported that their own organisations were going through major changes in terms of focus of work priorities, training and ethos. These changes appeared to be completely in line with the changes in service provision required for an effective prevention strategy and the initial proposals received unanimous support from all of those interviewed.

Our sample of young people had this to say about the prevention strategy:

“As young people and young adults, we need services that focus on preventing ill mental health and promoting resilience. It seems as though this would be beneficial not only for us as young people but also for the NHS as well as the general community. There would be less demand for treatment
and of course, less young people suffering with an illness that could have potentially been prevented.”

“Promoting resilience and wellbeing practices through school and education will be a great way to facilitate children and young people with the development of skills and knowledge that supports their mental health. Particularly if this is shared through innovative, modern techniques such as digital technology and social media.”

“Lack of awareness, understanding and appropriate support is often destructive for young people’s mental health. Through the implementation of aims and objectives stated in the prevention plan, there would be a significant improvement in children’s and young people’s psychological wellbeing”

“The earlier these skills are learnt the better! For me, as well as friends and family - developing skills such as this whilst at school would have been extremely beneficial and could have potentially lead to brighter future prospects, increased confidence and a much better ability to overcome difficulties.”

“I also support the idea of training parents, professionals and organisational groups to prioritise prevention, and to support young people in a way that promotes the prevention of issues, rather than the treatment of issues once things get severe. Prevention is always better than cure.”

“Champions would be great and are very much needed, however - it would be important for these champions to be representative and fully open to and informed about all types of people and their needs/differences. This would ensure that the strategies and policies champions are involved with are effective for all, rather than a select few.”

“I think it is a very well informed document entailing the pressing issues felt by young people but giving solutions to them as well.”

“Having gone through it myself and meeting people along the way, I know too many stories of people simply being treated as an issue, not a person, where medication was simply prescribed without tackling the root of the
problem. It was all about only helping people when they are already quite ill instead of trying to stop it from happening in the first place.”

“I think an aim should be also be to make it a key target to improve awareness for parents to prevent issues with their children. At the moment a long of young people have mental health problems, in most cases because no intervention was in place before things got too serious. Education and awareness is needed, the quicker the issue is confronted, the quicker young people can achieve mental clarity.”

“I definitely agree with training staff and increasing awareness to make sure that people are able to identify potential symptoms for young people who are at risk.”

“The key recommendations of prevention are aims that should be employed across all mental health services, particular for that of young people.”

“I like the idea of focusing on early years and training those that work with children and well as parents. I think this will have a significantly positive effect on a child’s mental health later in life. I agree that a multi-agency approach is the most effective way to make this happen. To ensure that this has the desired effect, I think it’s important to make it available and easily assessable for all parents and professionals.”
Reports and Policy

This brief overview of some of the most relevant reports and policies relating to prevention, clearly demonstrates that prevention is the preferred direction of travel to shape the future of mental health provision in England.

Future in Mind 2015

“What is needed is a fundamental shift in culture. A whole system approach is needed focusing on prevention of mental ill health, early intervention and recovery.” (Norman Lamb - Future in Mind 2015)

The ‘Future in Mind’ report summarised the work of the children’s and young people’s mental health and wellbeing taskforce set up by Norman Lamb and colleagues in 2014/15 and provided an in-depth review of the evidence and needs of the population in relation to improving mental health outcomes. It is currently one of the most influential documents in relation to mental health service provision for young people and is driving much of the transformation work currently in progress.

One of the five key priorities from the report is ‘Promoting resilience, prevention and early intervention’ and the findings support many of the proposed recommendations in the Birmingham review. Relevant statements from the report include:

**Early Years - Prevention**

“There is evidence that supporting families and carers, building resilience through to adulthood and supporting self-care reduces the burden of mental and physical ill health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities.

“If we are to have the greatest chance of influencing the determinants of health and wellbeing, we should focus efforts on actions to improve the quality of care for children and families. We should start by making efforts to ensure a safe and healthy pregnancy, a nurturing childhood and support for families in providing such circumstances in which to bring up children.”

“The Institute for Health Visitors is updating training given to all health visitors around mental health and the Department of Health is working with HEE, the Royal College of Midwives and the Maternal Mental Health Alliance to design training programmes for midwives.”
“Public Health England is publishing an update of the evidence base for the Healthy Child Programme (0-5 years) that will guide professionals including supporting early attachment between infant and parent(s).”

“By 2017, every birthing unit should have access to a specialist perinatal mental health clinician.”

“There is strong evidence of the benefits of evidence-based parenting programmes in intervening early for children with behavioural problems. These are benefits to the individual child and family, as well as producing significant cost saving to the system as a whole.”

**Schools**

“Evidence shows that interventions taking a whole school approach to wellbeing have a positive impact in relation to both physical health and mental wellbeing outcomes.”

“We encourage all schools (including those in the independent sector) to continue to develop whole school approaches to promoting mental health and wellbeing.”

**Digital**

“The digital world has become of utmost importance with its potential to protect and enhance the mental health and wellbeing of our children and young people.”

“The use of apps and other digital tools can empower self-care, giving children and young people more control over their health and wellbeing and empowering their parents and carers. Harnessing the potential of the web to promote resilience and wellbeing aligns with the principles set out in Personalised Health and Care 202048 and the priority it has already given to young people. Children and young people’s mental health and wellbeing should be given the priority it deserves.”

**Summary**

Much of what is needed can be done now by:

“Promoting and driving established requirements and programmes of work on prevention and early intervention, including harnessing learning from the new 0-2 year old early intervention pilots.”
“Continuing to develop whole school approaches to promoting mental health and wellbeing, including building on the Department for Education’s current work on character and resilience, PSHE and counselling services in schools.”

Future Planning

“Consider enhancing existing maternal, perinatal and early years health services and parenting programmes to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour by ensuring parents have access to evidence-based programmes of intervention and support.”

“Supporting self-care by incentivising the development of new apps and digital tools; and consider whether there is a need for a kitemarking scheme in order to guide young people and their parents in respect of the quality of the different offers.”
Five Year Forward View for Mental Health (2016)

In the most recent forward view document, prevention has again been emphasised as perhaps the major priority for enabling effective and sustainable improvements to services.

Some relevant excerpts from this report include:

“Prevention matters - it’s the only way that lasting change can be achieved. Helping people lead fulfilled, productive lives is not the remit of the NHS alone. It involves good parenting and school support during the early years, decent housing, good work, supportive communities and the opportunity to forge satisfying relationships. These span across national and local government, so the Taskforce has a set of recommendations to build on the Prime Minister’s commitment to a “mental health revolution.”

“Housing is critical to the prevention of mental health problems and the promotion of recovery. The Department of Health, the Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems.”

“People with lived experience of mental health problems, carers and health and social care professionals told the Taskforce that prevention was a top priority. Specific themes raised included support for new mothers and babies, mental health promotion within schools and workplaces, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing.”

“Many people discussed the importance of addressing the wider determinants of mental health, such as good quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement.”

Initial engagement

The five year forward view mental health taskforce engagement findings in 2015 surveyed 20,473 people including those with lived experience of mental illness as well as health and social care professionals with ‘prevention’ being one of three overarching priorities - with themes that emerged including:

- Support for new mothers and babies
- Mental health promotion within schools and employers
- Being able to self-manage mental health
- Ensuring good overall physical and mental health and wellbeing
• Getting help early to stop mental health problems escalating.

The report also identified novel approaches to improving community mental health with emphasis on building support for those at greatest risk of developing mental illness as well as including recommendations:

• Suggestions of using a ‘community asset’ approach, particularly in working with community and voluntary sector organisations, including faith-based organisations, to equip people with knowledge and skills to understand and manage their own mental health and that of those close to them - especially important within BAME communities.

• Calls for greater use of social prescribing, which links people with mental health problems into social activities in the community to improve intergenerational resilience and reduce loneliness and isolation.

• The importance of addressing the broader determinants of good mental health and mental health problems, such as good quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement.

• Recognition that much mental ill health arises from poverty, lack of social cohesion and feelings of lack of agency created by unequal society.

“The first argument we make in this Forward View is that the future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health. Twelve years ago Derek Wanless’ health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded -and the NHS is on the hook for the consequences.”

“The health and wellbeing gap: if the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.”

Public Health England (2014)

Public Health England reported in 2014 that one of their priorities was ‘Ensuring all children get the best start in life’.

“Getting a good start in life, building emotional resilience and getting maximum benefit from education are the most important markers for good health and wellbeing throughout
life. We know that 80% of brain cell development takes place by age three and how we care for infants shapes their lives. Early attachment and good maternal mental health shapes a child’s later emotional, behavioural and intellectual development. Enabling children to achieve their full potential and be physically and emotionally healthy provides the cornerstone for a healthy, productive adulthood. Socially disadvantaged children are more likely to have speech, language and communication difficulties than their peers, which has implications for their educational attainment and future life chances.”

Their report also recognised that a very high proportion of young people weren’t getting the best start in life with only 52% of children reaching a good level of development by the end of their reception year. (From evidence into action: opportunities to protect and improve the nation’s health - PHE 2014)

**Closing the Gap (2014)**

Closing the Gap report from the Department of Health in 2014 suggested 25 key priorities needing to be addressed in mental health provision to establish mental health support on a more equal basis with physical health - the priorities reported included:

- An information revolution around mental health and wellbeing
- Mental health care and physical health care will be better integrated at every level
- Change the way frontline health services respond to self-harm
- Offer better support to new mothers to minimise the risks and impacts of postnatal depression
- Schools will be supported to identify mental health problems sooner.

**Preventative Psychiatry (2011)**

In an evidence-based paper on the potential for a preventative paradigm in psychiatry, Bhui & Dinos (2011) reported on risk markers and intervention targets to prevent mental illness. They identified high-risk groups as including:

- Children with parents who have mental health or substance use problems
- Children experiencing personal abuse or witnessing parental domestic violence
- Looked After Children
- Children excluded from school
- Teen parents
- Young offenders
- Young lesbian, gay, bisexual and transgender people
- Young Black and minority ethnic groups
- Children in families living in socioeconomic disadvantage.
The overview reported that effective targets to improve mental health should involve:

- Pre-school and early education interventions
- School-based mental health promotion and mental illness prevention
- Prevention of violence, abuse and suicide
- Early intervention for mental illness
- Alcohol, smoking and substance misuse reduction and prevention
- Promoting healthy lifestyle behaviours
- Reducing stigma and discrimination

(Preventive psychiatry: a paradigm to improve population mental health and well-being - Bhui K & Dinos S BJP 2011, 198:417-419)

The Cost of Inaction - London School of Economics

In relation to the cost benefits of investing in a prevention of mental illness strategy - it is pertinent to consider the impact of not investing in prevention. Current best estimates for England suggest that between 55-64% of young people 16-25 with a current mental illness are not receiving a service or treatment suggesting that services are only identifying and treating a minority of those young people experiencing mental illness.

If this is considered in terms of current over-stretched services capacity to cope with even small increases in referral numbers - and reduced budgets for youth services reported by Young Minds - continuing to employ the same approach to mental health service provision is perpetuating a major disservice to the majority of young people in need. This further reinforces the message that prevention is vital if we are to address the true cost and prevalence of mental ill health in our communities.

Knapp and colleagues at the London School of Economics - who are international leaders in health economics for mental health have reviewed the evidence and conclude that

“To neglect mental illness in young people is not only morally unacceptable, but also an enormous economic mistake.”

They also recommend:

“Invest early to prevent or reduce the risk of mental health issues emerging during childhood and adolescence, for example though earlier and better recognition of maternal mental illness; anti-bullying efforts in schools; and better links to services that work with young people not in employment, education or training.”
“Reverse the downward trend in funding of child and adolescent mental health services in England.”

“Strive for better service coordination and integration. The consequences of failing to recognise or respond to mental health issues in childhood and adolescence can last a lifetime and can spill into many different public and private budgets. The relevant agencies - especially education, youth justice, health, social care, welfare benefits - need to work together to agree priorities and take the necessary actions.”

Early Intervention Foundation

The Early Intervention Foundation has published a report showing the increasing costs of late (or no) interventions and includes the following comment:

“The annual cost of late intervention is still unacceptably high at nearly £17bn and local authorities continue to bear the largest share. The human cost to children and young people is much greater and can have a lasting impact on generations of families. Councils know that we can make the strongest difference to children and young people's outcomes by investing in early intervention and preventative services before problems become entrenched and reach crisis point but the current financial context is tough and as the pressure on our budgets increases, so too does the pressure on these services.

“The report rightly states that there will always be a need to spend on late intervention, for example, by taking children into care when necessary, but we must get the balance right. For a while a period of double investment in both early help and high end child protection services will be necessary but in time we will realise the benefits.

“This will not be an easy undertaking and will be particularly difficult for deprived regions that are often supporting families facing more complex issues and social conditions but doing nothing is not an option - the risks for children and families is too great. There is a strong argument for a shift away from reactive spending but central government is not enabling this approach in local areas.”

Dave Hill, President, Association of Directors of Children’s Services
Birmingham Demonstrator Site - Outline Proposal

Context
In the sections above, WMAHSN made recommendations for a prevention strategy for mental illness to the Mental Health Strategy Board. These include:

- Focus on Youth and earliest years
- Work with Schools and Education
- Employ Digital & Social Media Tools
- Develop robust partnership models
  - Find appropriate ‘Champions’ in program activities

This section takes those recommendations (the ‘what’) and describes a series of activities (the ‘how’) which can employ them to deliver a range of health, wellbeing and economic benefits.

Proposal
The proposal is to establish two or three proof of concept/demonstrator sites for the implementation of integrated delivery of the prevention strategy. These will be designed to ensure effective evaluation, allowing us to gauge the impact of this novel combinatorial approach.

The unique aspect of this approach is the delivery of the recommended interventions in a coordinated fully integrated manner thus potentially benefiting from the amplified effect of evidenced based programmes working together and delivering enhanced outcomes.

As a regional organisation, WMAHSN is keen to support this process; initially to act as the ‘honest broker’ to establish a collaborative delivery partnership, and ultimately to drive the regional adoption of interventions as mainstream services that genuinely improve the lives of our citizens and service users, and help address the region’s financial challenges.

This outline proposal does not seek to be prescriptive about the details of service models, or who commissions and provides them. Rather, it proposes a set of principles that should underpin the approach to optimise the chances of success.
Principles
Given the dependency of this work on collaborative partnership working, the following principles should be applied to the planning and delivery of the proof of concept/demonstrator sites:

Return on Investment & sustainability
☐ While initial pump-priming will be needed, any successful service model must be able to demonstrate that long term funding will deliver sufficient health, wellbeing and economic benefits to merit being commissioned as a mainstream service.

Sharing costs, benefits and risks
• The work is dependent on the support of many organisations and individuals. They will need to recognise and respect each other’s constraints and ambitions, and manage costs, risks and benefits accordingly.

Co-design and co-production
☐ Service design will need to meet the needs of different sectors, organisations, professions and citizens. Each must have the opportunity to assure that the design and implementation of services meets their needs.

Not ‘reinventing the wheel’
☐ The Prevention Strategy document has identified several service models that can be adopted or adapted in the demonstrator sites. Every opportunity to use what has already been proven should be exhausted before initiating the ‘ground-up’ design of new services.

Promoting positive community messages
☐ Establish the importance of the prevention approach i.e. improved school readiness at age five or reduced school exclusion.

Approach
The scope of this work is subject to a wide range of variables impacting cost, complexity and timescale, and a clear business case needs to be in place before potential commissioners/sponsors can assess viability and affordability. It is therefore recommended that a two-stage approach be taken, beginning with a robust feasibility study.
Stage 1 - Feasibility Study
This would be a time-limited (3 to 6 months) exercise to determine:

Geographic scope

- Initially focusing on small localities acting as demonstrator sites with potential for spread across larger areas (STP footprint) as outcomes/benefits become apparent

Stakeholder mapping

- To determine the appetite and existing activity and capacity among stakeholder within defined localities

Identifying metrics

- Specific, measurable criteria will be needed to identify and select a demonstrator site or sites, and to evaluate the effectiveness and return on investment for future, mainstream roll-out. These will also be used as baselines to demonstrate tangible improvements.

Resource Investigation

- To identify current, future and potential resource support, to include mainstream commissioning and provision budgets, as well as short-term funding (e.g. NHSE Test Beds, Vanguards, EU funding and commercial investment opportunities)

Note: This work will not duplicate or revisit the work undertaken to produce the Prevention Strategy, but produce firm data resulting in a business case which defines input and output metrics, and gives a clear indication of return on investment, measured in health, wellbeing and economic terms.

Stage 2 - Demonstrator Sites

Based on the output from the feasibility study, this would:

- Identify two or more demonstrator sites (based on clear criteria from the feasibility study)
- Define the cost of implementation and evaluation
- Establish clear leadership and governance
- Produce a detailed plan for the design, delivery, evaluation and mainstream adoption of a prevention service
- Identify and commit resources
  - Provide the commissioners/sponsors with sufficient information for a ‘go or no-go’ decision
Resource Implications

The cost of full implementation will only be known following the feasibility study. Indicative costs of the feasibility study will need to include:

- A dedicated project manager
- Stakeholder mapping and engagement
- Establishing and consulting on selection and evaluation criteria
- Production of a business case for demonstrator site(s)

If this were to run from June to November 2017, a figure of £75K would cover this. WMAHSN would once again be prepared to host and co-ordinate this work, maintaining the involvement and commitment of the various partner organisations.

For further information, please contact:

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Appendix A

Prevention: Focus on Early Years & Perinatal Support - reducing the impact of childhood adversity

**Why?** There is robust evidence from the research literature and recent reports that the most productive and cost-effective element of any prevention of mental ill-health strategy will be during a child’s early years. Reducing the experience and impact of adversity in childhood and building support and interventions for early years parenting, perinatal needs and in school, provides the greatest opportunities for improving long-term outcomes.

**How?** Building on already existing programmes of work and developing a comprehensive training platform for staff. An early identification and intervention programme for those most at-risk with appropriate validated interventions and monitoring. This will require active partnership and multi-agency working to make most effective use of available resources and support. For Birmingham, this will involve working closely with already established partnerships to ensure best use of resources and sharing of expertise to build a lasting programme of work. In the evidence sections we have chosen to focus on validated interventions already operating in the local region.

**Evidence: Early Years Overview**

Early years begins with pregnancy and encompasses the main development stages prior to five years of age.

Converging evidence from neuroscience, psychiatry, and epigenetics demonstrates that the influence of adversity and ‘toxic stress’ in the early years can have a dramatic and detrimental impact on emotional development and resilience that extends over a lifetime. The developing brain is highly sensitive to environmental stress - particularly during the first three years - but throughout infancy and childhood. Adverse home environments (e.g. neglect, abuse, domestic violence, parental mental illness or substance use) can alter the evolving brain structure to quickly become more sensitised to stress arousal with associated negative impact on higher cortical development and immunological functioning. With chronic exposure to adversity this has been found to fundamentally alter the child’s ability to self-regulate emotions with consequences for fundamental learning and education readiness, pro-social behaviour, and both physical and mental health. In a major epidemiological study conducted by the World Health Organisation across 21 countries it was established that 30% of all mental illness conditions were directly attributable to adversity in childhood.
Responsive care giving from parents, carers, extended family and appropriate support and interventions from child care professionals - associated with secure attachment formation - have been related to better self-regulation, attention, and socio-emotional functioning in children, whereas insecure or disorganised attachment is associated with increased risk of mental ill-health.

Almost twenty years of research into the impact of adverse childhood experiences (ACE’s) has robustly demonstrated that these early experiences are associated with global impairments to emotional regulation, immunological resilience and learning capacity in a close response relationship. This leads to a consequent heightened risk of behavioural difficulties, physical and mental health conditions, impaired social behaviours and earlier mortality. We give a more detailed summary of this research below. The risk of experiencing adversity in childhood and development of mental illness is further exacerbated by poverty and socio-economic inequity with factors including low income level, social disadvantage and residence in urban environments - with some of this impacting through epigenetic pathways. This carries the further implication that children and families living in many deprived Birmingham regions are likely to be at increased risk.

**Perinatal mental illness**

Perinatal mental illness (commonly depression, anxiety disorders, and postpartum psychosis) occurs in approximately 10-20% of mothers within 12 months of giving birth and approximately 10% of fathers. It is also associated with disruption to involved attentive parenting and negatively impacts on the formation of a secure attachment with the child as well as increased risk of suicide of the parent.

A recent report from the London School of Economics estimates that perinatal conditions cost the UK economy approximately £8.1 billion for each one-year cohort of births, equivalent to around £10,000 per year for every single birth in the UK, and result from poor identification and intervention programmes for this group as approximately 50% of women with perinatal mental health problems are not identified nor offered support, despite effective treatments being available. It is predicted that up to 8 out of 10 pregnant women will downplay the symptoms of the illness when in fact suicide is one of the leading causes of death amongst women during pregnancy. In a report by Bauer, Parsonage, Knapp, Lemmi & Adelaja (2014) it was reported that the average long-term cost of perinatal depression, anxiety and psychosis on society is of about £8.1 billion for each one year cohort of births in the UK, from which around £1.2 billion is spent by the health and social care, £0.5 billion is spent through other public sector organisations and
£6.4 billion represents the cost towards wider society. Of all these costs, only 28% of it is related to the mother, whereas the other 72% is related to the cost of adverse effects on the child.

Despite the current societal costs of perinatal mental ill-health, Bauer et al. (2014) stated that services are patchy, with approximately 40% of women in England not having access to perinatal support and around 15% of the localities that do provide these services do not do so to the level recommended by the National Institute for Health and Care Excellence (NICE). It was suggested that in order to bring England to the standard for perinatal mental health recommended, an extra NHS expenditure of around £280 million year would be needed.

Recommendations from the NICE perinatal guidelines include taking more preventative approaches towards mental health such as ensuring that women understand that mental health problems are not uncommon during pregnancy and post-natal periods through the provision of culturally relevant information. It is also stated that professionals should consider referring a woman to secondary mental health services for preconception counselling if she has a current or past severe mental health problem and is planning a pregnancy. In addition to preventative recommendations, NICE also has a series of guidelines all in place since 2014 regarding the treatment of mental health problems occurring during the perinatal period. Nevertheless, as it was described above, around 40% of women in England don’t have access to perinatal mental health services suggesting a big gap between recommended guidelines and service delivery.

As of 2018/19 NHS England intend to allocate £20m to specialists perinatal mental health community service development fund. Despite this much needed funding; it is not enough to cover all the treatment of mental health services for pregnant women and their families. It would be appropriate to begin investing in preventative measures such as those recommended by NICE e.g. educating the wider population about mental health problems during pregnancy; assess likelihood of mental health problems in pregnant women or women who are seeking to become pregnant; generate an action plan for treating high-risk women involving psychotherapy and social prescribing during both pre-natal and post-natal periods.

**Attachment**

Attachment refers to the affective bonds that exist between an individual and an attachment figure or caregiver. In the case of babies, it refers to the emotional connection between them and other/s significant people in their lives. According to Crittenden & Claussen (2000), the quality and characteristics of this affective bond will serve as a basis for the child to
build an inter-personal strategy or schema on how to respond and process social information as well as detect and react to danger and threats. The quality of early attachment relationships will determine how well the child develops, how they cope with life ups and downs, establish and maintain relationships, and develop psychological and physiological resilience to stay physically and mentally healthy.

During early stages of development, even during pregnancy, a foetus begins to form an attachment with their parent. After birth, the baby will begin to attach to a primary caregiver through behavioural signals such as making eye contact with the caregiver or mirroring the carer’s facial expressions. The bond or attachment between caregiver and infant is consistently strengthened as the child is comforted when scared/sad, fed when hungry, and is generally made feel safe. This form of positive and secure attachment can only take place if the primary caregiver provides consistent and attuned responses to the infant (Wimmer, Vonk, & Bordnick, 2009).

Responsive caregiving from parents, carers, extended family or even child care professionals have been related to better self-regulation, attention, and socio-emotional functioning in children as they develop in comparison to children who did not receive this kind of care (44-46). Moreover, it has been shown that securely attached children experience lower levels of anxiety and more positive emotions, and later on tend to develop more successful relationship with teachers and peers than insecurely attached children (53-54). This is due to the way positive attachments influence the development and maturation of the endocrine and immune systems. As the attachment figure serves the child as a secure base to turn to when distressed in order to seek reassurance and comfort; if the carer or secure base is inconsistent, neglectful or abusive the stress management system does not shut down adequately or is activated too easily. This is ‘toxic stress’ and can lead to a dysfunction of the immune system such as increased likelihood of suffering from asthma, hypertension, cardiovascular disease, mental health problems, and even cancer.

There are several factors, such as going through the foster care system, experiencing institutionalisation at an orphanage, receiving inconsistent care, or experiencing neglect or abuse from a caregiver, that interrupts the process of attachment formation. This disruption can often cause the child to develop a disordered attachment style (Becker-Weidman, 2008).

There are two main types of attachment problems in children - insecure or avoidant attachment styles. and attachment disorders. RAD or Reactive Attachment Disorder has two main subtypes: emotionally withdrawn or inhibited pattern of RAD, and indiscriminate or
disinhibited RAD (APA, 2000). The first refers to a child exhibiting minimal or no attachment behaviour even when distressed and be socially disengaged in general. They may also be unable to reciprocate emotions or find it difficult to regulate emotions in the first place. In the second type of RAD, the child fails to show developmentally appropriate reserve around unknown adults. For example, the child will engage socially with strangers with little or no resistance, or they may even approach a stranger to ask for help or seek physical comfort or affection (Lake, 2005).

Stinehart, Scott, & Barfield (2012) stated that children with RAD can present symptoms of their attachment disorder prior to the child’s first birthday such as inability to being comforted, failure to gain weight, severe colic or feeding difficulties or atypical unresponsive behaviour for an infant. As the child continues to grow, they may also show unusual food consumption behaviour such as food hoarding, gorging, or eating foods with no nutritional value (e.g. paper). Moreover, RAD has been related to display of extreme mood swings, depression, and inattentiveness during adolescence (Lake, 2005), and criminal behaviours such as stealing, vandalism, violent behaviour towards others, animal cruelty, and no signs of regret or remorse (Stinehart, Scott, & Barfield, 2012).
Figure 1 above represents the pattern of attachment formation and the impact a negative type of attachment can have on both the individual and society as a whole. Impact of attachment related problems are very costly for the UK. For example, the cost of cardiovascular disease to the UK economy was of £29.1bn in 2004 (Luengo-Fernandez, Leal, Gray, Petersen & Rayner, 2006), the cost of hypertension was estimated to be of £2bn to the NHS (PHE, 2014), and the cost of conduct disorder-related crime in England may be as high as £22.5bn per year (Knapp, McDaid, & Parsonage, 2011).

School readiness

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. Children in the UK generally start school by five years of age but there are many children who are at this age not yet at a level where they can benefit fully from the general school environment. School readiness is assessed using markers collectively described as a ‘good level of development’ (GLD). Children are defined as having reached a GLD at the end of the Early Years Foundation Stage if they have achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in specific areas of mathematics and literacy. If children
have not reached a GLD prior to engaging with primary school, they are more likely to have ongoing problems with social and physical skills, reading and maths. There are longer term implications for educational attainment, health, criminal behaviour and mortality. It can be more burdensome to improve their attainment level at later stages. There are both individual and societal factors involved in GLD readiness and factors that have been identified as having impact including:

- Maternal mental health - children of mothers with mental ill-health are five times more likely to have mental health problems themselves
- Learning activities, including speaking to baby and reading with children - a child’s communication environment is a more dominant predictor of early language than their social background. Language proficiency is a key predictor of school success
- Enhancing physical activity - Only 1 in 10 children Aged 2-4 meet CMO guidelines of being physically active for at least 180 minutes (3 hours), spread throughout the day
- Parenting support programmes - 4 in 10 children miss out on ‘good’ parenting
- Effective, warm, authoritative parenting gives children confidence, stimulates brain development and the capacity to learn
- High-quality early education - If all low-income children received high-quality early education the gap in achievement could be closed by as much as 20-50% - the average economic benefit of early education programmes for low income 3 and 4 year-olds is nearly 2.5 times the investment

High-quality early years education significantly improves child health and educational outcomes, particularly for disadvantaged children

**ACEs, epigenetics and toxic stress**

The growing evidence base from ACE’s research over the past 20 years has robustly established that adverse childhood experiences such as domestic violence and abuse are directly contributing to adult mental illness and additionally to almost every major current education and public health concern. This topic should inform every element of a prevention strategy beginning with a dedicated education intervention for all key professionals involved in health education social care and emergency services. This approach has already begun in Birmingham and is currently being explored and applied in other areas of the UK. It is becoming one of the more universal elements of the rationale for a prevention model.

ACE’s research describes a body of work on the relationship of childhood exposure to different types of adversity that developed from a public health programme for obesity initiated by Vincent Felliti in the 1980’s in San Diego USA. In 1998 Fellitti and Robert
Anda carried out the ACEs study, which for over 15 years followed and measured 17,400 participants for a series of health harming behaviours and disease in adulthood and compared these to ten categories of adverse childhood experiences. The study found a significant dose-response correlation between the number of ACEs experienced and the amount of health harming behaviours and disease participants experienced in adulthood. As example, participants with four or more ACEs compared to those with no ACEs had a 4 to 12-fold increased risk for alcoholism, drug abuse, smoking, depression, and suicide attempts; as well as a 240 percent greater risk of hepatitis, 390 percent greater risk of chronic obstructive pulmonary disease (emphysema or chronic bronchitis), and a 240 percent higher risk of a sexually-transmitted disease. They also had a 1.4- to 1.6-fold increased risk of being physically inactive and severely obese.

This study has been further replicated across America and Europe robustly establishing the connection between ACEs and negative behaviour and health outcomes. Replication studies have been commissioned in England and Wales including in Blackburn, Hertfordshire, Luton and Northamptonshire. Bellis et al. were the first to carry out this study in England with almost half (47%) of the participants experiencing at least one ACE and 9% four or more ACEs (rising up to 12.7% for those in the most deprived areas). It is important to note that the dose-response of cumulative ACEs associated with long term negative outcomes even in individuals who display otherwise healthy lifestyle behaviours. It is thought that this is related to the impact of early acute and chronic stress responses on the DNA telomeres - protective caps which guard against immunological damage alongside an epigenetic failure on the coding of the allostatic system.

The biology of adversity suggests that children who experience toxic stress may be less able to benefit from good quality early childhood programs because of impairments in their developing brain circuitry. This proposition is supported by extensive evidence (from both animal and human studies) of the vulnerability of the amygdala, hippocampus, and prefrontal cortex (PFC) to the disruptive effects of excessively activated stress response systems, beginning in the prenatal period and early infancy and, in the case of the PFC, extending well into the adult years.

**ACE’s stress and allostasis**

Allostasis refers to changes in biological systems responsible for maintaining physiological stability. These systems work by detecting environmental and physiological changes in order to activate adaptive responses which ensure internal regulation. There are three highly integrated systems involved with this specialised response, the nervous, the endocrine, and the immune systems. When under stress, the brain signals the hypothalamus and pituitary gland to stimulate the adrenal gland to produce adrenaline and cortisol. These hormones
stimulate alertness and attention to the environment, and induce the activation of the sympathetic nervous system ‘fight or flight’ response.

When active, psycho-social stress triggers inflammation, an immune system response to prevent infections in case any tissue damage should occur during fight or flight and also activates the neuroendocrine system by increasing metabolic demands and mobilising stored energy to further support the fight or flight response. This process involves highly integrated and adaptive systems which promote short-term adaptation in the face of environmental challenges. Chronic or repeated exposure to psychological stressors, such as adverse childhood experiences, has been linked to a prolonged activation of the allostatic systems causing allostatic overload or toxic stress.

In a literature review carried out by it was found that the chronic exposure to psychosocial stressors leads to structural and functional abnormalities in the brains prefrontal cortex, amygdala and the hippocampus causing behavioural manifestations such as impaired attention, memory and emotion regulation. It has also been hypnotised that chronic stress exposure is involved in the genesis of psychopathology and cognitive deficits as well as mental illness, e.g. high levels of cortisol have been linked with positive and negative symptoms in schizophrenia and first-episode psychosis.

Physiological effects of chronic stress exposure can be genetically transferred through epigenetic changes - modifying genetic programming and changes in gene function without changing genetic sequences. McGorry, et al. argue that identifying epigenetic differences that cause pathological behaviour is of utmost importance in generating therapeutic and preventative approaches to potentially reverse epigenetic changes. The adverse childhood experiences (ACES) checklist has provided a unique opportunity for us to detect children that are being exposed to chronic stress and interrupt the trajectory leading to mental illness.

**ACE’s Training**

All statutory and non-statutory service providers who are working with young people or parent-child services should be required to attend a general introduction training that includes modules on ACE awareness. This should involve an overview of general physiological and emotional / biological mechanisms of responding to stressful / threatening situations in early developmental time-points and also an introduction to the outcomes associated with high ACE’s in a dose response manner. All those who are trained should also receive training in applied attachment parenting models (as differing from common behavioural approaches to parenting / interacting with young people who have experience
trauma) and in availability of resilience building interventions and support via online website hubs.
Training should be interlinked with a hub of supportive information as part of the digital strategy and a ‘care pathway’ navigation advice for what to do if you feel that too many ACEs are interfering with your life in a negative way.

Summary

- Extensive evidence from neuroscience, psychology psychiatry and education research has established that the negative impact of significant childhood adversity is immediate and lifelong/enduring
- The pathogenic mechanism of early adversity is via chronically activated stress-response systems (the fight/flight/freeze response) leading to profound (and in some cases - irreversible) harm to normative brain development - with particular emphasis on the amygdala, hippocampus, and prefrontal cortex (PFC) regions. These impacts are associated with reduced cognitive capacity, ongoing threat-bias and sensitivity to stress and impaired immunological protection.
- These vulnerabilities are exacerbated within difficult social and environmental conditions
- The increased risk associated with early adversity extends across many major physical, mental and public health priorities, and in early years on the capacity to learn and benefit fully from educational opportunities.
- Recent advances in developing effective early interventions to reduce the conditions and consequences of early adversity offer a range of effective strategies to create more positive outcomes for those at-risk.
- Interventions include attachment-focused parenting; family nurse partnership models, behavioural and targeted interventions for pre-school years.

These are essential target stages for preventative and early intervention services as they have a disproportionately high influence on the child’s development and likelihood for future mental health problems. Key factors that influence a child's wellbeing during this period and later on in life are: maternal mental health, epigenetic factors, attachment, and adverse childhood experiences (ACES). Neuropsychological evidence suggests there are distinct brain developmental stages that mirror these periods with important implications for the likely efficacy of any interventions.

Recommendation

Build on already existing programmes of work and developing a comprehensive training platform for staff and early identification and intervention programme for those most at-risk with appropriate validated interventions and monitoring. This will require active partnership
and multi-agency working to make most effective use of available resources and support. For Birmingham this will involve working closely with already established partnerships to ensure best use of resources and sharing of expertise to build a lasting programme of work.

References


Partnership working

Birmingham Services Currently Working with Early Years

- **St Paul's Community Development Trust**
  Services from 0-11 yr olds: 5 pillars of parenting programme, baby matters programme (baby massage, weaning, bottle to cup workshop, oral health, music session and first aid courses), advice workshops and mentoring functionality skills, outreach pre and post natal visits (support), healthy start (baby nutrition), parents matter (parent support group), pregnancy matters (antenatal classes), Henry programme (health, exercise, nutrition for the really young - tackle childhood obesity), primary services for autistic children (playgrounds). Services from 11-19 yr olds: independent school for children 11+ that experience difficulties in mainstream education due to emotional social or health difficulties and/or SEN; and a junior college 16-17 for young people with barriers for education - whilst providing work experience and mentorship.

- **The Priory group**
  Services for schools, and they also run five residential care homes for children in Birmingham but do not offer mother and baby support.

- **Our Sorority**
  Our Sorority-Birmingham UK provides a wide range of practical support through mentoring, workshops and family support for young women aged 15-25 - work support, training and education, work experience; training on safer parenting, promoting social inclusion. We do this by giving guidance and practical support to vulnerable young women who are (but not limited to) at risk of offending, abuse, substance misuse, poverty, exploitation, child protection orders, managing their mental health, NEET and who feel excluded from society.

- **NSPCC Child Protection**
  PANTS campaign, raising awareness in schools & the community of child CSE for professionals, children & young people in an appropriate format. Assessing the risk (assessing of adults that could be at risk to children), protecting the child, face to face support, graded care profile, SafeCare, and taking care.

- **My Time**
  MH services - therapy, community peer led services, research, family therapy \ Family action for cochoice tomorrow - MH & domestic violence - BME focused IAPT
provider predominantly around Asian services (Punjabi, Hindi, etc.). They offer residential care, employment support (training and apprenticeships), supported living (help build independent living skills), crisis support, treatment services (complex needs and addictive behaviours), preventative services (advice, training, consultancy), community based support (stigma challenges, gain confidence, engage in activities), peer support, career and family support.

- **Muslim Women's Network**
  Training for Muslim women about CSE risks for young people. Support & signposting for those affected. Information, advocacy, research/training, and campaigning: (1) Sharing understandings of gender in Islam from a human rights perspective; (2) Sharing knowledge of gender equality in UK family laws, marriage and divorce; (3) Changing attitudes to abuse against women and girls; (4) Changing attitudes to mental health; (5) Changing attitudes to women's leadership; (6) Supporting actions to address Islamophobia and discrimination.

- **Malachi**
  Work with schools, councils and agencies to identify and support families who are facing difficulties. In schools, they offer a range of services including parenting classes and one-to-one therapeutic intervention. They also undertake larger government or social investor funded projects. Specialist family support services - Malachi parenting program (inspiring futures), drama projects (6 musicals - peer pressure, bullying, relationships and citizenship), school staff care, classroom workshops and summer school, family support (1:1 therapeutic family support). Staff care (1:1 session counselling for staff and clinical supervision); separated parents working together (therapy)

- **Loudmouth Theatre Company**
  Loudmouth is a ‘theatre in education’ company that uses drama and discussion to help children and young people address issues affecting them in a safe and interactive environment. Our programmes come in different formats to suit your needs from focussed delivery to a class at a time to our popular Year in a Day format for drop down and theme days. Education programmes involve: bullying,
relationships, solidarity and altruism, safe & sound, trust, alcohol and substance misuse awareness, domestic violence and SA/SE. Training on: CSE, PSHE, domestic abuse, sexual diversity, GP surgeries.

Impact
Believe those that are willing to dream, dare, and have a heart for a better Birmingham need a place where they can realise these dreams - A place to collaborate and discuss, challenge and be challenged, provoke and be provoked; a place where paradox and contradictions can cohabit with ease; A platform where they can meet like-minded creators and disruptors and where they can continually challenge themselves and others. At Impact people are able to come into the hub to carry out training and projects on a wide range of topics from social activities to social advocacy and awareness campaigns; organisations can also rent out spaces to provide training that abides to the ethos.

Health Exchange
Public health, primary care information and advice (walk-in centres), and they run targeted specialist services and campaigns around mental wellbeing, health and wellbeing, breast feeding peer support, pre-diabetes work, training for health trainers, health checks, social prescribing, primary care walk-in centres, smoke cessation, obesity prevention, IAPT delivery, healthy eating, being active, cancer support, support with long-term conditions management and prevention, and mental wellbeing prevention services. They are also managing agent for the MH consortium BMHC who have been commissioned to deliver IAPT services on behalf of the CCG through Birmingham Healthy Minds for 18+ and FTB for 14+.

Family Support & Safeguarding Team - BCC
Working to reduce the effect on children of domestic abuse, mental health problems, and drug or alcohol use by parents; Working to prevent family breakdown; Working with families to meet the Think Family guidelines for troubled families. In particular, families where: children aren’t going to school regularly, one or more parents are unemployed or parents don’t have enough time to look after their children; Offering advice about the impact of substance misuse, domestic abuse, mental health issues, sexual exploitation and antisocial behaviour; Offering parenting advice; Arranging one-to-one sessions with children or young people; Undertaking assessments of children who may be a ‘child in need’; Making sure that the Council does everything that it must do to help the most vulnerable children.
Family Learning
Offer learning courses and online information for children and families in the areas of reading, numbers, healthy living, education systems

Family Action
Practical, emotional and financial support for those experiencing poverty, disadvantage and social isolation. Family Action’s Children & Families Services work with children, young people, parents, carers and the wider family network to ensure the family is able to realise its full potential (stable and positive family networks). Our work supports families when they face complex needs and challenges -including domestic abuse, substance misuse and mental health issues - and it ranges from intensive family support, specialist therapeutic work, conflict management and relationship support, and advice and wellbeing services.

Bethel Doula Service
Provide emotional support to vulnerable, isolated, and asylum seeking women in Birmingham who are pregnant a part of the Bethel Health and Healing Network. Support is provided by giving a friendly birth partner, helping find essentials such as baby clothes, nappies, and moses baskets, breast feeding support, hosting a weekly mother & baby group, running a fortnightly parent education & health class, providing friendly emotional support. Staff are trained on a range of topics such as breastfeeding, to safeguarding and female circumcision

Amirah Foundation
Support for Muslim women and children with homelessness, poverty, forced marriage etc. Our core aim is to facilitate vulnerable women to play a more active role in society and unlock their full potential and social capital. This is achieved through working to eradicate poverty, tackling homelessness and providing services that support women fleeing domestic violence. Additionally Amirah Foundation provides a leadership role in relation to the key challenges and issues faced by Muslim women and their children living in the UK. They do this by helping vulnerable women with finding accommodation, accessing benefits, providing with essential items to start life, counselling, parenting programmes, food bank. They are also currently carrying out three campaigns: Fighting back (against domestic violence), Say no (training courses in school about domestic violence and other related issues), and New Neighbours (a programme to support refugees)

• Anawim’s Family Support
Anawim offers rehabilitation sessions (including professional training), financial/debt advise, drug/alcohol rehab, counselling, group counselling for trauma survivors (TREM - Trauma Recovery and Empowerment), advocacy, family support, prison services, housing services, community/street outreach, family services (antenatal, baby courses, emotional support, parenting, etc.), early interventions for criminal behaviour, domestic violence.

### Action for Children

Action for children provides emotional and practical support for children, families, and carers. To help under-fives get ready for school our services include: child and family health services; parenting programmes and antenatal support; early year’s education services, such as ‘stay and play’ sessions; speech and language support and family learning. They run the Triple P parenting programme (recognised by the EIF). To help under-fives get ready for school our services include: child and family health services; parenting programmes and antenatal support; early year’s education services, such as ‘stay and play’ sessions; speech and language support and family learning. In addition we offer support for parents with adult learning and employment support. This may include language, literacy and numeracy support, family learning, access to apprenticeships and volunteering opportunities as steps toward employment.

### Acacia Family Support

Offers Pre and Postnatal depression support services to families across Birmingham. They provide, free of charge, services which include individual befriending sessions, group work therapy, telephone support, practical support in your own home and massage therapy for parents and their baby. They also support the entire family. Train midwives, SU, volunteers about post-natal depression.

**Birmingham services providing interventions relevant to ACE’s**

- **Child Parent Psychotherapy (Lieberman model)**: a psychoanalytic intervention targeting mothers and preschool children (aged three to five) who may have experienced trauma or abuse (e.g. domestic violence), or are otherwise at risk of an insecure attachment and/or other behavioural and emotional problems. Specifically, CPP aims to improve children’s representations of their relationship with their parent and reduce maternal and child symptoms of psychopathology.

  EIF evidence score: 3  
  Cost: Unavailable  
  Level of Need: Targeted / Indicated  
Amirah Foundation: offers support for women and children through finding accommodation, counselling, crisis intervention, accessing benefits, providing with essential items to start life, counselling, parenting programmes, and food banks. They are currently carrying out three campaigns: Fighting back (against domestic violence), Say no (training courses in school about domestic violence and other related issues), and New Neighbours (a programme to support refugees); and three workshops: Imams Project (awareness raising of domestic violence, honour based violence, forced marriage, FGM, sexual violence and exploitation program on hard to reach sections of the Muslim community), mental health awareness workshops (5 ways to mental well-being, first aid to mental health, anxiety course, assertiveness course, among others), and school workshops for years 10 and 11 on recognising abusive relationships and the effects of sexism within popular culture.

Anawim

Prison Services: Assisting them with a wide range of different tasks, applying for accommodation, and making contact with solicitors, social workers and family members as requested. We also refer them to other organisations that can offer additional support, such as drug and alcohol services. Our goal is to ensure that as the women approach release they have a network of support ready for them in the community and that they are re-connected with family members.

Rehabilitation Services: Alternative to custody for women involved in the criminal justice system with severe offenses and re-offending history with multiple needs. Interventions include: financial and debt advice, drug and alcohol support, counselling, accommodation advice, health support, one to one support, support with family issues, advocacy, courses (including academic courses), and employment support.

Barnardos CEOP: The NCA's CEOP Command (formerly the Child Exploitation and Online Protection Centre) works with child protection partners across the UK and overseas to identify the main threats to children and coordinates activity against these threats to bring offenders to account. Barnardos protect children from harm online and offline, directly through NCA led operations and in partnership with local and international agencies. They protect children from becoming victims of sexual exploitation and sexual abuse, and prepare interventions to reduce the impact of child sexual exploitation and abuse through safeguarding and child protection work. Barnardos liaise with the online and technological industries, fine-tuning guidelines to minimise the possibility of present and future technology increasing the risk of sexual exploitation and sexual abuse to children. Their training and education
specialists work together to raise the knowledge, skills and understanding of parents, carers, children and young people

- **STaMP (Schools Training and Mentoring Project)**: a programme delivered by St Basils to prevent youth homelessness. The programme consists of a training element delivered in schools as part of PSHE for pupils in years 10 and 11, and a peer-mentoring element. Aim of this session is to enable young people to understand the leading causes and triggers for homelessness amongst young people and the impact this creates in later life chances.

- **The Children's Society - Children and Family Zone (CFZ) model** - influenced by the Harlem Children’s Zone, New York, USA - The core of the CFZ is in Solihull’s three children’s centres: Kingshurst, Yorkswood and Castle Bromwich. This programme is set out to improve the lives of children and families in the most deprived areas by providing free support in the form of parenting workshops, a pre-school program, [chartered schools](#), and child-oriented health programs for thousands of children and families. Moreover the Children’s Society provides advocacy services, children centres for refugee and asylum seekers and destitute families, missing from home services and child sexual exploitation prevention programmes such as streetwise.

- **Place2Be** provides emotional and therapeutic services in primary and secondary schools, building children's resilience through talking, creative work and play. Place2Be works with a school population of around 116,000 children, helping them to cope with wide-ranging and often complex social issues including bullying, school transition, bereavement, addiction, domestic violence, family breakdown, neglect and trauma. They provide training workshops, training for teachers, professional advice, and training school leaders. For children: individual and group counselling; For parents: dedicated therapeutic support. For head teachers and school staff: training, individual advice and support.

- **The Lateef Project** is a free confidential Islamic telephone counselling service for the Muslim community and people related to the Muslim community in Birmingham. It is a registered charity. It works in partnership with the NHS in Birmingham. It is set up for people who are experiencing mental health problems in order to provide support for people who are dealing with difficult matters; these can range from emotional distress, such as relationship problems, stress, loneliness, etc to physical distress such as domestic violence, assault, drug and sexual abuse and also mental
distress such as depression and anxiety etc, or it can be for someone who simply needs a listening ear, to talk through a difficult situation.

- **Beyond the Horizon Charity** is a mobile counselling service for young people 4-16 years of age & their families whose lives have become challenging after family breakdown, bereavement or domestic abuse. We support children & young people through counselling and other activities to achieve hope for a healthy future, emotional well-being and reduce their need for more intensive support. All counsellors are professionally qualified and deliver support at community venues within a mile radius of the home address to facilitate easy access.

- **Birmingham & Solihull Women's Aid** provides emergency accommodation, community support services and a helpline to support women and children affected by domestic abuse and other violence against women issues.

A full table of mapped service providers in Birmingham can be found in Appendix E
Birmingham Services currently operating in early years

**Evidence Based**
- Mellow Parenting\(^1, 2\)
- Toddler-Parent Psychotherapy \(^1, 2\)
- The Five Pillars of Parenting \(^1, 4, 5\)
- Parent as Partner \(^1, 2, 4\)
- Family Nurse Partnership \(^1, 4\)

**VCS Programmes**
- Malachi Inspiring Futures Programme\(^2\)
- Thrive Approach \(^2\)

**VCS General Support**
- Malachi Family Support \(^4\)
- Acacia Family Support \(^3\)
- Anawim Family Support \(^2, 3, 4, 6\)
- Birmingham & Solihull Women’s Aid \(^6\)
- Health Exchange Breastfeeding Peer Support \(^5\)

**Early Years Interventions**
- Toddler-Parent Psychotherapy \(^1, 2\)
- The Five Pillars of Parenting \(^1, 4, 5\)
- Parent as Partner \(^1, 2, 4\)
- Family Nurse Partnership \(^1, 4\)

**Birmingham**
- BSMHFT - Mom and Baby Units \(^2, 3\)
- Multisystemic Therapy \(^1, 4, 5\)
- Incredible Years \(^1, 4, 5\)
- Triple P Positive Parenting - Action for Children \(^1, 2, 4\)
- Signs of Safety \(^4, 6\)
Appendix B

Prevention: Work with Schools and Education

Why? Schools, colleges and universities are essential components of any preventative response for youth mental health. Evidence confirms that the majority of mental illness first emerges during the school years, and it’s still the case that the majority of individual cases of mental ill-health are not identified nor offered appropriate treatment at the time. It follows that there is a clear rationale to develop prevention strategies that involve education settings as core elements. The majority of young people who are at the key risk age for emerging mental illness will already be attending schools and colleges, so prevention programmes must collaborate with educational establishments to enable a successful risk identification and early intervention strategy to succeed.

Evidence - Promoting resilience in schools

During adolescence and particularly secondary school years - many parts of the brain are maturing and connecting with particular activity in areas which underlie reasoning, information processing, abstract thinking, long-term planning, and the regulation of behaviour and emotion. This period is often associated with high levels of risk taking and a degree of emotional instability which is particularly emphasised in those who have been exposed in early childhood to adversity or trauma. It is during this period that any latent vulnerability can be exposed and there is a consequent heightened risk for emerging mental disorder associated with this time period. Children with poor mental health tend to miss school more frequently and have fewer employment prospects (Harvey, Henderson, Lelliott, and Hotopf, 2009), impaired social relationships, worse physical health and substance misuse problems, and are more likely to be involved in offending (The Centre for Social Justice, 2011).

Transitions into school and especially between primary and secondary school are often key points of stress vulnerability. Some children are more at-risk than others of experiencing a negative transition into secondary school such as male children from socio-economically deprived families (Serbin, Stack, and Kingdon, 2013); children who are in social care (Brewin and Statham, 2011) and those with disabilities (Berquez, Cook, Millard, and Jarvis, 2011) who have been found to have more problems in adapting to the transition and experience a less positive educational experience. Those involved in bullying (either as bully or victim) are more likely to develop depression (Ttofi Farrington, Lösel, and Loeber,
2011), anxiety (Copeland et al., 2013), eating disorders, psychosomatic symptoms (Due, Holstein, B. E., Lynch, J., Diderichsen, F., Gabhain, et al., 2005), self-harm and suicide ideation (Espelage and Holt, 2012). These factors lead these children to be less likely to experience professional, social, and economical success later on in life; and to be particularly vulnerable to developing mental illness.

This evidence suggests that it is important to identify any protective factors that enable children to build emotional resilience and thrive through school transitions. Resilience refers to the possession of protective factors that help individuals overcome adverse conditions successfully (Zolkoski and Bullock, 2012). On a systematic literature review Zolkoski and Bullock (2012) classified all protective factors into five categories:

- **Individual characteristics** (e.g. positive temperament, autonomy, socially oriented, secure attachment, intelligence, optimism, good health, motivation, and good coping skills)
- **Self-concept** (positive self-esteem, self-aware)
- **Self-regulation** (easy going, positive emotion and exuberance, use of opportunities around them)
- **Family conditions** (authoritative parenting style, family structure, family cohesion, supportive parent-child connection, parent's intimacy, stable adequate income, stimulating environment)
- **Community support** (neighbourhood safety, recreational facilities, economic opportunities, religious/spiritual organisations, relevant support services).

Puccioni (2014) investigated the impact of parental support and found that parent's 'school readiness' belief was positively associated with their use of positive transition practices (such as language, literacy, and numeracy activities at home) with their own children. In turn, this predicted children’s academic achievement after transition; and school readiness beliefs were associated with continuous academic growth. The authors reported additional protective factors of making new friends and having a relationship with an adult (e.g. teacher), they suggested that friends foster one-another's self-esteem, well-being, and support when experiencing difficulties - and peer-support or mentoring systems may have a positive role to promote positive engagement and health.

This reinforces the evidence that schools are an appropriate target for resilience building and targeting those at high-risk of mental ill-health for monitoring support and early intervention strategies.
Resilience is often described as the capacity to ‘bounce back’ from difficult experiences or adversity without being essentially harmed or injured. The evidence suggests that whereas there are some protective factors that can provide buffers against the impact of stress such as early secure environments and positive attachment - resilience is something that we have to learn through experience, ideally with guidance and support. It involves learning to employ the personal and environmental resources available at times of difficulty in order to get back to a situation of homeostasis or stability.

Mental ill-health is also associated with social inequity with those who experience greater hardship and deprivation generally having a higher risk of developing mental health difficulties and less likely to have developed optimal resilience strategies. This is where schools can really make a difference in providing support for vulnerable students through transitions, promoting education and support for healthy behaviours and encouraging more cohesive interpersonal relationships through peer support, mentoring, emotional literacy and healthy communications.

Staff training in the importance of building resilience and healthy school practices and the awareness of the impact of childhood adversity on risk for mental health outcomes are essential. Adopting a whole school ethos where resilience building and wellbeing are priorities of school functioning and healthy practices are encouraged across staff, parents, students and the community are thought to be particularly effective in reducing stress and increasing a range of positive behaviours and wellbeing for students. Building confidence through promotion of positive experiences and involvement in activities such as sports, arts and music are also thought to enhance academic resilience.

A whole schools approach that is currently being promoted in a pilot in Birmingham schools is based on the ‘Academic Resilience’ programme developed by Hart & Williams at the University of Brighton & the wellbeing organisation ‘Boing Boing’ working with Young Minds.

Mental health literacy and understanding of children's emotional development and the impact of adversity is generally inconsistent across schools and education professionals with little appreciation of the close relationship between secure attachment, emotional regulation and academic attainment. The ability to both target those individuals at high-risk of
developing mental ill-health and of applying both universal and targeted wellbeing and resilience strategies is appealing.

Cost analyses suggest that schools bear an inordinate percentage of the financial burden for supporting individuals with mental health needs and young people who are at risk of exclusion will often have underlying mental health difficulties driving their behaviours. There has in recent years been a great deal of investment in research that helps to identify individuals with vulnerabilities and risk markers for mental illness but less systematic promotion of schools’ resilience and wellbeing or development of exemplary care pathways and cross-agency working with health and social care partnerships.

Local Evidence: Birmingham Prevention of Mental Illness Schools Model

Birmingham has recently benefited from multi-agency reviews of best practice and interventions to improve resilience and wellbeing / reduce mental illness as well as the formation of the Birmingham Education Partnership-Wellbeing board to support these strategies in a consistent multi-agency approach. A review of evidence and regional activities suggests key elements for holistic model of resilience and wellbeing strategy

Involvement in the early stages of the Big Lottery funded Headstart programme allowed for a strong multi-agency partnership to develop in Birmingham and a real exploration of models of school resilience, wellbeing and early intervention. Working with expert advisers and informed by national leads in resilience training the Birmingham ‘Newstart’ programme is currently piloting the core elements of a bespoke intervention programme in nineteen Birmingham schools across the city. This whole-schools approach is underpinned by an Academic Resilience Model and is an excellent foundation for a prevention of mental illness strategy with a clear emphasis on influencing the ethos and responses of staff in a whole schools approach to resilience building and prevention. Key elements of this programme include:

- Working with schools in each of the 10 districts of the city
- Employing strategic well-being leads who are senior staff trained in the Academic resilience approach. These staff work across the schools to build best practice at Transitional points through childhood and adolescence and to raise the whole-school awareness of Prevention work through good training, excellent resilience and wellbeing work and seamless care pathway relationships with specialist care providers.
- Intervention schools are twinned with a partner school to enable both comparison and sharing of best practice in real time.
Currently this work is funded until the end of the academic year 2017/18 but funding has not been available to build the additional elements of the full model which include the integration of a community and digital strategy.

**Community elements** would include employing staff who can work with the key schools and develop universal level support including:

- develop detailed knowledge of community resources that schools can use and work with the digital offer to map these;
- undertake bespoke research to identify local community support where existing knowledge of community based resources does not lead to identification of this;
- engage community based providers of support in discussions about the creation of new responses where no community based support is found following the bespoke research;
- support community groups and partners to access to training / awareness raising / partnerships that will ultimately improve well-being of young people;
- work with parents, so that they feel a greater connection and awareness of the offer in their community and how to access that support;

- support the implementation of a youth offer within each district. This should include a group of young people who will also receive training and support on mental and emotional health to act as peer mentors, anti-stigma campaigners and a way to capture new ‘intelligence’ of issues affecting young people in their schools and communities.
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Schools currently involved in Birmingham’s ‘Newstart’ Schools Intervention Programme:

<table>
<thead>
<tr>
<th>Recipient School</th>
<th>Partner School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardinal Wiseman</td>
<td>Hamstead Hall Academy</td>
</tr>
<tr>
<td>Holy Trinity School</td>
<td>Bordesley Green Girls School</td>
</tr>
<tr>
<td>Erdington Academy (Formerly Kingsbury School)</td>
<td>Fairfax Academy</td>
</tr>
<tr>
<td>The International School</td>
<td>Queensbridge</td>
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<tr>
<td>Cockshut Hill</td>
<td>Ninestiles Academy</td>
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<tr>
<td>Baverstock School</td>
<td>Swanshurst Girls School</td>
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<tr>
<td>Moseley School</td>
<td>Hall Green School</td>
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<tr>
<td>Four Dwellings Academy</td>
<td>Lordswood Girls</td>
</tr>
<tr>
<td>Ark Kings Academy</td>
<td>Colmers</td>
</tr>
<tr>
<td></td>
<td>Bishop Vesey Grammar School</td>
</tr>
</tbody>
</table>

Digital elements of a holistic school model could include building a dedicated website run in co-participation with school staff and students to promote trusted educational materials and resources on resilience and wellbeing alongside the possible introduction of additional online therapeutic support and training resources (see ‘digital’ section).

Evaluation

The potential to contribute to the evidence around what are the most effective interventions to build resilience and prevention of mental illness in schools allows for extensive evaluation and a systematic, complex and in-depth comparison design including process system and economic aspects of evaluation, peer-led Interviews and discussion groups, case studies, journey mapping, observations, creative (photo, art etc) and youth-led research (this could attract PhD interest from local academic partners). Qualitative research can be planned with schools alongside quantitative outcome measure evaluations.
Cultural diversity is important to acknowledge in Birmingham as for example research from the Aap Ki Awaaz Project in Birmingham identified a perception that mental illness is not culturally accepted in some communities and that many individuals hold a sense of fear and shame because of this, and a desire to keep mental illness secret. Culture, stigma, language barriers and lack of awareness all contribute to a closed perception regarding mental health in some communities.

The impact of this on young people and their beliefs about mental health as they grow up must be fully understood, in order that the work Newstart is doing within schools and reaching into families and communities "...is not left behind at the door when children get home". However there is limited published evidence around this, and how such perceptions, beliefs and barriers can be overcome, in order to provide more culturally sensitive support services that families and communities will engage with, in order to support young people.

Provisional Recommendations: Build on current strategies with Birmingham Education Partnership (BEP) and key multi-agency representation through the Birmingham Education and Wellbeing group ('NewStart'). Focus on transitional points through childhood and adolescence to raise the whole-school awareness of Prevention work through good training, excellent resilience and wellbeing work and seamless care pathway relationships with specialist care providers.

Metrics: School readiness GSD; CORC (Newstart); Risk and Resilience markers including Strengths & Difficulties Questionnaire (SDQ)

Additional Evidence-Based Interventions currently active in Birmingham Schools

Good Behaviour Game: The Good Behaviour Game (GBG) is classroom management strategy that encourages good behaviour and co-operation in children in primary school classrooms. Teachers initiate Good Behaviour Games by dividing children into small teams that are balanced for gender and child temperament. Teams are rewarded with points for good behaviour in short games that take place several times a week. GBG has initial evidence of improving children’s behaviour, reducing substance misuse and sexual risk taking. Mentor is leading the first randomised controlled trial of the GBG in the UK, which is a two-year project taking place 2015-2017 in Birmingham, Manchester, Barnsley and the surrounding areas.

EIF evidence score: 3  Cost: Unavailable
Level of Need: Low
FAST (Families and Schools Together): is for any parent or carer of a child between the ages of three and eight who wishes to support their child and become more engaged in their community. Parents and children attend eight weekly sessions where they learn how to manage their stress and support their child’s development. After parents ‘graduate’ from the eight-week programme, they continue to meet together through parents’ sessions that occur on a monthly basis. FAST has established evidence of improving children’s social skills and reducing their aggression and anxiety. FAST also has evidence of reducing parents’ social isolation.

EIF evidence score: 4  Level of Need: Low/Moderate


BEP - Academic Resilience Model: (described above as ‘Newstart’)
Academic resilience means students maintaining good emotional health and achieving good educational outcomes despite adversity. It will help the school establish systems to build the ‘Academic Resilience Model’ that supports students through a whole school approach. It will benefit all students but particularly those who are disadvantaged. It will help raise achievement. It involves strategic planning and detailed practice involving the whole school community to help vulnerable young people do better than their circumstances might have predicted.

Evidence-Based Interventions for Parents Struggling with Child’s Behaviour

The Solihull Approach Parenting Group (also known as Understanding Your Child’s Behaviour): is a universal parenting intervention for any parent with a child between the ages of 0 and 18. Parents attend 10 weekly two hour sessions for groups of 12 parents. Parents identify personal goals and the strategies that will help meet them, and reflect on their child’s behaviour and their relationship with their child. The Solihull Approach emphasises containment, reciprocity and behaviour management.

The programme begins with a home visit, where parents are expected to identify personal goals. Parents then monitor their progress in relation to the goals originally identified at the first home visit. Parents can be signposted into more intensive programmes if it is felt that their needs are not being met.
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EIF evidence score: 2 Cost: 1
Level of Need: Universal

**Triple P:** P is a Targeted-Indicated intervention for parents with a child between zero and 12-years old who have concerns about their child’s behaviour. Groups of up to 12 parents attend sessions over eight weeks delivered by a single trained and supervised clinical psychologist. These sessions include five two-hour group meetings, as well as three (15 to 30 minute) individual telephone consultations. Parents learn up to 17 different strategies for improving their children's competencies and discouraging unwanted child behaviour. Role play, homework exercises and discussions involving video-taped examples of effective parenting strategies are used to help parents learn methods for dealing with unwanted child behaviour and supporting their child’s emotional needs.

EIF evidence score: 3 Cost: 1 Level of Need: Targeted/Indicated

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Young Minds academic resilience for schools see:
http://www.youngminds.org.uk/training_services/academic_resilience/what_is_academic_resilience
Appendix C

Prevention: Digital Tools & Resources

Why? Digital resources, tools and interventions are an essential element of any proposed strategy that focuses on mental health particularly for prevention and early intervention approaches.

How? Digital covers two interrelated areas:

   iii) Information, evidence, training and best practice networks via an online hub

   iv) Developing digital resources and intervention tools to build resilience and prevent mental illness

These can be used across all (Universal) community / organisational / educational and public groups to raise awareness, promote self-help and resilience building strategies, reduce stigma and encourage sharing of best practice. Building robust partnerships with the local digital industry and social enterprise we can design and pilot innovative solutions to support mental health resilience building and wellbeing.

Digital resources, tools and interventions are no longer merely optional but an essential element of any proposed strategy that focuses on mental health particularly for prevention and early intervention approaches and those that may involve young people and education. Developing a digital training platform integrating webinars, clinical simulation courses, blended elearning, podcasts and a digital library of resources will ensure fidelity of high-quality training across all staff specialisms.

We propose as a function of a pro-active Prevention Partnership Board contributing to a single point of access website functioning as a ‘front door’ for all key service mapping, training and education promotion relevant to the Birmingham/regional prevention strategy - working alongside agencies to integrate and support best use of local digital services and information.

Evidence

The prevalence of individuals using the internet has been increasing exponentially since it was first launched, with around 88% of adults in the UK using the internet during a three-month period in 2016, compared with 86% in 2015. Importantly almost all young people aged 16 to 24 years are regular internet users (99.2%), with many utilising the internet to find instant, easy to access support for mental health issues such as anxiety, depression and eating disorders. Recently, a study into young people’s use of the internet found that
73% of young people relied on media such as social networking sites and other websites to get information on the topic of self-harm, compared to just 11% who sought information from healthcare professionals such as their GP or CAMHS professional.

It is clear that digital information and communications have become a key component for any comprehensive strategy supporting the prevention of mental ill-health with research finding that online mental health services do have a positive effect on help seeking behaviours, awareness of mental health disorders, and engagement and use of online treatments.

Evidence also suggests that the use of online mental health services is increasing and may influence access to care and likelihood to seek support. According to a recent ChildLine report, the year 2012/13 was the first year in their records in which more counselling took place online rather than by telephone; with 59% of counselling sessions online increasing to 68% of counselling sessions online for 2014. Yet there have also been recent findings that many people are not aware of the potential or existence of online self-help tools, blended therapies and trusted information on mental health matters.

Young people of the current generation are brought up as digital technology natives and almost all will learn to employ internet based tools early in their educational and social lives. Online technologies have permeated every aspect of healthcare over the past two decades and increasing access to interactive technologies such as tablets and smartphones suggests the necessity for any health care provider to integrate digital education, training and intervention resources wherever possible. Sources such as the Young and Well Cooperative Research Centre in Australia have produced increasing evidence that digital technology is a protective factor in the promotion of mental health and the prevention of mental ill health. In England the Department of Health has set out an information strategy over a 10-year framework for transforming information for the NHS, public health and social care. Many digital mental health resources are available around the clock and can be made to suit individual schedules. People can access from their personal smartphones, tablets or home computers reducing the need for travel and additional waiting. These interventions tend to be cost effective and also enable many of those difficult to reach to access support and help.

Digital technology can also have a valuable role in the provision of training platforms for staff such as clinical simulation training courses and interactive elearning, webinars and podcasts. In addition to more traditional training, the use of engaging and interactive digital training platforms can greatly enhance capacity to roll-out specific elements of new practice or maintain fidelity of approach across or between services in varied locations. If training provision is accompanied by real-time feedback from those trained - the ability to update and tweak training materials and focus is keeping the service relevant and appropriate.
Digital Hub

Many local key agencies have already developed their own external facing digital information, engagement and promotion websites but it can still be very difficult for the public and even professionals to navigate services / new initiatives and appropriate educational resources. We propose as a function of a pro-active Prevention Partnership board (see below) to agree cross-agency funding for a single point of access website functioning as a ‘front door’ for all key service mapping, training and educational event promotion relevant to Birmingham with live updating a function of a small funded ‘digital navigation’ team - working alongside agencies to integrate and support best use of local digital services and information.

- Involving commercial organisations with specialist expertise in digital innovation represents a significant opportunity to deliver benefits quickly and cost-effectively. The public sector has a track record of attempting to develop in-house solutions which often fail to lever the latest technologies and can prove more expensive than commissioning from specialist developers. This has been particularly advanced by the AHSN in the region.

- Appropriate online training, resources and interventions should remain the responsibility of each element of the partnership (eg focus on wellbeing/resilience / online safety for schools; mental health conditions and specialist training for NHS etc) - with an integrated research and evaluation academic component.

- Inclusion of best evidence online resources and interventions appropriate to each setting (we have already reviewed the current evidence for online interventions which will be included as part of the final report)

- Inclusion of Social Prescribing as a key element of a community focused digital prevention strategy - building on the local Pilot work of Dr Paul Turner and colleagues at the Karis Health Centre

We give an example of how a digital hub could be developed and employed from a schools / educational perspective below.

Example: Digital Education Hub

We have previously explored the needs and potential for digital support with prevention of mental illness and promotion of wellbeing and resilience within schools in Birmingham as part of the Headstart pilot programme. Some of this research involved included:

- Focus groups research exercise on the topics of positive transitions, communications and Well-being in schools involving young people and teachers.
A Delphi study of recommendations for schools transitions and well-being including a focus on digital communications and online training.

A survey of the status of online safety policies being employed across 419 Birmingham primary and secondary schools.

Reviews of impact of digital on mental health resilience and wellbeing.

Our findings informed a business case for a comprehensive ‘digital hub’ recommending:

- Comprehensive online safety training to be provided to all relevant staff and students
- A dedicated website focusing on wellbeing and resilience information to be developed in collaboration with school staff and young people who can manage and develop this resource in co-participation with wellbeing leads across a school partnership
- A review of appropriate Apps and online resources to be considered for the website
- Develop opportunities to work with regional digital industry partners to collaborate on building dedicated resilience and wellbeing resources (eg smartphone Apps) capable of collating outcomes and feedback on secure server to identify targets of peak stress and helpful interventions.
An example of how a schools-focused dedicated website hub could function is in the diagram below:

**Birmingham Example: PocZero**

PocZero is an innovative social enterprise in Birmingham and exists to improve the lives of individuals through improved wellbeing from a holistic perspective, focusing on developing a sense of purpose, a connection to family, friends and communities, along with physical, mental and financial aspects. PocZero are currently working with Birmingham agencies to combine digital, community and health information strategies to encourage people to take positive responsibility for their own health in community settings.
Birmingham example: Social Prescribing

A pilot model of social prescribing has been active in Birmingham for the past year based at the Karis clinical hub in Edgbaston. Social prescribing describes a community / digital approach that aims to improve a person’s health by tackling their social and physical wellbeing without the use of medical treatments. The concept originated through the work of Antonovsky (1987) who rejected the traditional medical model and dichotomy that separates health and illness. Instead he described health as being a continuous variable, and underlined the value that a sense of control has over a person’s wellbeing. Since then, social prescribing has been promoted as a low cost - high impact intervention as it aims to achieve long term behavioural change, reduces inappropriate reliance on prescription medicines and cost of primary care services. It typically involves programmes offering exercise groups, support with healthy eating, and emotional support groups.

Currently in the UK there are six forms of social prescribing: Five Ways to Wellbeing, bibliotherapy, art engagement, eco-therapy, exercise, volunteering and community groups, and learning prescriptions.

In addition to the positive effect that each method of social prescribing can have on the individual, it is the capacity that it brings to the individual of being autonomous and show self-efficacy that also contributes to their mental health and wellbeing. Studies exploring the efficacy of social prescribing on mental health and wellbeing found a positive impact with stakeholders (patients and general practitioners) perceiving social prescribing as responsible for increasing service users’ mental wellbeing and decreasing health service use. However, despite these positive findings, social prescribing is fairly uncommon in England, with most services located in the North West. Further efforts should be directed at increasing and advertising the many resources currently in place (e.g. green spaces, parks, museums, art galleries, etc.) that provide a non-medical treatment alternative.

Recommendations: Work with industry and key education, health and social care and community organisations to develop i) an interactive web based digital information and training website hub in collaboration with key stakeholders including young people and carers associated with NHS services and ii) identify from reviews or develop with digital industry supportive tools and resources that enable resilience and wellbeing alongside early identification of risk. Ensure young people and service users are actively involved in the implementation and delivery of these solutions. Develop strong collaborations with additional current projects and with industry partners to inform best practice in digital solutions for prevention of mental illness.
References


Department of Health (2012). The power of information. Putting all of us in control of the health and care information we need.

Appendix D
Prevention: Integrated models of youth mental health services

Why? Although evidence suggests the greatest impact for prevention of mental illness would likely involve an intense focus on early years, families and perinatal support - and there is general agreement that 50% of all mental illness emerges prior to age 15 - a new type of service provision is only just emerging. Traditional statutory models of mental health service in the UK separate child and adolescent (CAMHS) and adult (AMHS) services generally around the 16-18 years age point with poor liaison and transitional experiences reported. Thresholds for acceptance into services are often high and preventative strategies - although advocated in recent policy documents - are often patchy or non-existent. Resource availability drives much of this situation with funding received by CAMHS services averaging less than 1% of total NHS budgets (and adult services receiving 11-12% of NHS funding) - against a context of 23% of total health burden accounted for by mental ill-health. The current situation reflects the comment of leading youth mental health advocate - Professor Pat McGorry who suggests ‘the system is weakest where it should be strongest.’

Context
- Approximately 1 in 10 children and young people aged 5 - 16 and 1 in 6 young adults aged 16-24 have a diagnosable mental health disorder at any one time - many more at some point over this age range. Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm and this is increasing.
- Most mental health problems start in childhood and adolescence, half by age 16 and 75% by age 25. (Kessler et al, 2005). More than half of all adults with mental health problems were diagnosed in childhood - less than half were treated appropriately at the time.
- Perinatal mental illness affects at least 10% of mothers with high negative impact on their children if left untreated - estimated to cost the UK economy over £8 billion annually.
- 30% of mental illness is directly attributable to adversity in childhood - with a dose-response relationship. Adverse Childhood Experiences (over 50 publications) are related to increased pre-school cognitive and behavioural difficulties; increased depression; anxiety; suicide attempts; homelessness; youth imprisonment; early school drop-out; alcohol & substance misuse; high risk sexual activity & teenage pregnancy; domestic violence perpetration - amongst other negative outcomes.
Mental Health spending accounts for 11% of the total NHS budget in the UK (and 23% of the total burden of healthcare). Of this, only 7% of NHS mental health budgets go to CAMHS suggesting that only 1% of the total NHS budget is spent on child and adolescent mental health services (DoH 2008/9).

To enable optimal success of a mental health prevention strategy - services need to be aligned with the principles of prevention and early intervention, offering low-stigma community focused engagement and treatment options, commitment to early years, perinatal and family work and close liaison and integration with education, social care and third sector wraparound provision.

Against the context of youth mental health services being re-commissioned in Birmingham UK we have previously carried out a review of ‘best-practice’ in regional and international providers.

Evidence
A review of the components of ‘best practice’ for youth mental health service models and a series of individual interviews and focus group consultations with key stakeholders (including service users, carers, clinical staff and third sector support organisation leads across Birmingham) was completed during 2014-15. This work - funded by the West Midlands Academic Health Science Network - established key recommendations for the core elements of an appropriate youth model including:

- Co-participation with young people at all levels of service design and implementation
- Focus on prevention and early intervention with ethos of recovery and hope
- Elimination of discontinuities at times of greatest need (transitions and age ranges)
- Single point of access across care pathways
- Social inclusion, education, employment and constructive time use as core outcomes
- Inclusion of families and carer’s in planning and evaluation
- Best practice interventions for a wide range of disorders
- Focus on ameliorating emotional distress over diagnostic categorisation for access to service
- Effective partnerships with statutory and third sector agencies across health, social care, vocational, educational, housing and forensic services within regions
- Training in MH literacy for all staff working with young people as well as parents and young people in schools and colleges
- Training for BME community leaders, and young outreach BME staff in youth mental health and engagement.
• Specialist youth mental health workforce with the right skills attitude and training
• Close integration with schools to bring education and mental health together
• Online digital hubs for training, support and education with statutory service support
• One-stop centrally located centres to improve early help-seeking and reduce stigma
• Models of care reflecting the latest understanding of developmental processes and emerging adulthood - emphasising clinical staging.
• Proportionate and ring-fenced funding streams reflecting an emerging and vital professional specialism

A brief review of national and international ‘best practice’ models of Youth Mental Health Services was also carried out and brief descriptions of active examples of active models is below:

- **Headspace** is a comprehensive enhanced primary care model for youth mental healthcare from Australia operational since 2006. Working across the 12-25 age range it provides multidisciplinary youth friendly service hubs linking with schools and specialist services to an early intervention model and sits on top of existing primary care services.

  Importantly Headspace integrates physical, sexual and drug disorder services within their mental health hubs. This increases their utility and reduces stigma for users. To date over 85 centres have been established across the country, with some adapted to regional settings. Headspace incorporates an accredited educational and training programme, active youth participation, school support and web based digital education and interventions (eheadspace) alongside a real investment in ongoing research and evaluation (Orygen) with positive evaluation.

- **Headstrong** is the recent innovative model of youth mental health from Ireland. It demonstrates the most comprehensive example of meaningful integration of young service users in the development of the service, in response to the high levels of unmet need reported. In the Irish model, young people are consultants and key agents for change in developing drop-in hubs with local and statutory and third sector stakeholder organisations. The process involves generating local awareness and buy-in through a process of education and training to maximize the support and availability of specialist resources for young people aged 12-25 and to improve care pathways. This enables rapid access to appropriate interventions in non-stigmatising centres.
Forward Thinking Birmingham was recently commissioned and launched in April 2016 as a fully integrated Mental Health service focusing on prevention, early identification and intervention for all 0-25 year olds across the city. Key targets for this new service model include: clear navigation and simple access to the appropriate service; no duplication of services or gaps between services; providers working together effectively in support of individual needs; a range of preventative initiatives including support from universal services that promote emotional resilience and access to a wide range of targeted and specialist services so that more people can avoid unnecessary hospital admissions by being supported in the community. This unique approach should provide a real opportunity to evaluate how issues of transitioning, information sharing across providers and universal education can be engaged in an evolving comprehensive programme within a demographically diverse urban environment. One element of this model - the city centre Pause community drop-in provides an innovative example of a low-stigma open access resource designed in co-participation with young people that is driven by a prevention ethos.

Solar BSMHFT is the new model for 0-19 year olds in Solihull that has a preventative ethos and is integrated with community and statutory services in the region providing youth appropriate mental health services and engagement with community partners and overcoming traditional transition issues across child and adult providers.

Norfolk UK has developed a new service approach to working with 14-25 year olds has been established since 2013 with some reengineering of the existing child and adolescent services and recovery teams, targeting those with emerging serious mental illness in an assertive outreach approach.

The Specialist Youth Mental Health Service (SYMHS) model emphasises vocational and functional outcomes over a focus on symptoms alone, is driven by robust research and knowledge transfer and is well integrated with local vocational educational and third sector youth organizations to enable positive transitions out of service and improved care pathways into the new team.

Many other countries are investing in research to identify appropriate strategies for their youth mental healthcare needs. In 2014 Canada launched the ‘ACCESS Canada’ five year project to address youth mental health across the provinces using a Canada-wide research network and focusing on improving access to evidence based interventions for the 11-25 year age group.

In the US there is growing recognition of vulnerability in the young adult population and The Institute of Medicine and National Research Council recently recommended that young adults of 18-26 years are treated as a discrete group with priority given to improving the transition from paediatric to adult medical and behavioural health care, enhancing preventive
care for young adults, and developing evidence-based practices alongside additional resources to support existing mental health services and schools in promoting improved mental health in young people across a range of projects.

In New Zealand, the Prime Minister’s **Youth Mental Health Project (YMHP)** was launched in 2012 aiming to help prevent the development of mental health issues and improve young people’s access to youth mental health services with up to 26 initiatives phased to deliver improvements for young people by July 2016. One example is the SPARX e-therapy initiative for 12-19 year olds for the treatment of depression and low mood combining Cognitive Behavioural Therapy (CBT) techniques and gamification to engage young people.

The European Union funded **Adocare project** has recently investigated the status of adolescent mental health provision, training priorities and provision across ten EU states suggesting many inconsistencies and gaps in optimal provision for youth mental health across the countries taking part.

**Psychologically Informed Environments (PIE)**
Recent research into organisational capacity for reflection and empathic working has found that training staff in PIE and similar reflective models has very positive impacts on the engagement of staff with service users and the emotional wellbeing of staff and ethos of workplace. In Birmingham much of this work is being employed in a collaboration between St Basils youth homeless centre and the University of Birmingham Sports Psychology department alongside Forward thinking Birmingham.

PIE involves training of all staff in an organisation and hosting of regular reflection sessions where staff can discuss pressure points and specific work related events within a supportive forum with encouragement of problem solving and seeing the world from another’s perspective. This work has received positive results from current evaluations and there is now a programme of PIE work including training courses for staff and teachers alongside specific interventions. Malachi who are working in Birmingham provide a similar but alternative training course on this topic that should be considered and the Birmingham Local Authority have also invested in reflective capacity of their Early Years staffing.
Summary

‘Prevention and early intervention’ have become encouraging mantras for those working on system change for youth mental health. The epidemiological evidence showing how the majority of mental illness first emerges in youth, alongside better understanding of risk factors and changes occurring in the early stages of illness, allows for a discourse of prevention and an attitude of hope to establish in staff and teams working with younger populations.

This builds on the example of public health promotion in physical health care and success of early detection and intervention programmes for mental disorders such as psychosis alongside better understanding of developmental processes such as attachment and emotional regulation in early childhood and the impact of adversity and trauma on affective and cognitive development.

These foundations have allowed for clear intervention targets to emerge with appreciation of applying the right intervention at the right time avoiding the fostering of both service dependency and institutionalisation on one side or overlong treatment delay with missed opportunities for a ‘light-touch’ therapeutic tonic at the other. However incorporating these lessons into new and efficient models of mental health care for young people leads to practical questions such as consideration of age range to focus on, model parameters and staff expertise, user involvement, partnership working and issues of cost and benefits which have to be discussed in the context of local needs and funding priorities. Although a template of elements of ‘good practice’ may be possible to develop, it is unlikely that ‘one hat’ will fit all regional priorities and demographic diversity. What is clear is that strong local leadership and service ‘champions’ will be required to steer positive and lasting change against the current backdrop of economic uncertainty and competing health priorities. Providers will need to engage actively with local funders and policy-makers to ensure new approaches are adequately understood and supported.

Recommendations

The Forward Thinking Birmingham and Solar BSMHFT models provide an appropriate and essential statutory youth mental health component for a ‘proof of concept’ programme. Consideration should be given to building on the Pause community resource to provide low-stigma engaging support from within a community setting and building on current partnerships training and interventions particularly within school settings. A reflective practice model such as ‘Psychologically Informed Environments’ (PIE) or a similar approach to improving reflective capacity and engagement of staff should be an element of ongoing practice in organisations that work with emotional wellbeing.
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References


Appendix E

Prevention of Mental Illness Project: Birmingham Service Mapping Exercise - Interactive Table

Description (table on attachment)

The mapping exercise included a list of 219 organisations / services located or accessed in Birmingham & Solihull areas that are associated with prevention work at some level. A coding for these organisations was developed in blue, yellow, or red.

- **Blue** represents social prescribing services such as social activities, art projects, culture/religious integration activities, sport centres, and youth engagement projects.
- **Yellow** represents those services that did not have an available website or the organisation’s name led to two or more similar services.
- **Red** is for organisations where funding has been withdrawn but their website or service was still running at the date in which it was added to the table.

The first 26 columns of the table provide basic information such as the organisation’s name, address, contact details, primary aim / service provision goal, and origin of funding. This is followed by 14 columns that class the age range the service targets (nine categories) and role within the service (five columns: YCP, Parents/Families, Schools, Professionals, Notes). This is followed by the organisation specifications including range, group specific (e.g. BAME women), employee numbers, etc. followed by an indication of the dimension and level of intervention the organisation provides. The concepts of dimension and intervention levels were taken from the definition of prevention used by the World Health Foundation (2015).

**Levels of prevention:**

1. **Primary** - preventing mental health problems from occurring in the first place by using ‘upstream’ approaches. (e.g. such as parenting skills and attachment training, emotional literacy classes in schools, healthy eating school programmes, etc.)

2. **Secondary** - Identifying the earliest signs that mental health is being undermined and ensuring early intervention is available to minimise progression into a more serious mental health problem.

3. **Tertiary** - Working with people with established mental health problems to ensure the earliest path to sustainable recovery and to reduce the social, economic and health losses often resulting from living with a mental health problem.
Dimensions employed:

- **Universal**: seeking to influence a whole population or groups within institutions such as workplaces, schools, colleges.

- **Selective**: seeking to reach individuals or subgroups based on known areas of generally higher risk, including those who may not be showing signs of developing a mental health problem but live in circumstances or with discrimination and stigma known to be corrosive to mental health (BME communities, people who are homeless, people who have learning disabilities, LGBT community, etc.).

- **Indicated**: targeting people at the highest risk of mental health problems and potentially showing early indications such as employees who are displaying signs of workplace stress, children whose parents have a serious mental health problem.

In order to determine the area of intervention, a list of 53 risk factors for mental ill-health was compiled from the literature, including the Adverse Childhood Experiences checklist, and the organisation’s area of support itself.

Once the intervention level, dimension, and areas were established, the following 17 columns provide information on the type of intervention used e.g. counselling, group sessions, information, advocacy, followed by three columns on whether the organisation has future prevention programmes in planning; four columns that evaluate the available intervention programme in relation to ACEs and Early Intervention Foundation literature, and 12 further columns representing the 12 areas of risk employed by Forward Thinking Birmingham.

All data gathered from the organisation was coded as “1” if the organisation provided that service, or left blank if not with each row representing a single organisation. E.g. Row 51 is Birmingham Counselling Services which provides bereavement services, so there is a ‘1’ in row 51 under the “Bereavement/Loss” column. In order to search for how many organisations from the list provide a particular service or intervention all that is required is for the viewer to go to the title column and ‘click’ on the downwards arrow which will open an option menu. Once in there, tick the “1” option to show only those organisations that fit the category. This can be combined with as many columns/categories as required to find organisations providing multiple services e.g. selecting the ‘Tertiary Level of Intervention’, ‘BAME community’, and ‘Household Violence/Domestic Violence’ columns to obtain a list of all the organisations providing a tertiary level of intervention for the BAME population in Birmingham that are victims of domestic violence.
Please note that most services accept service users of different ethnicities, genders, ages, and those marked as BAME special services are only those that explicitly state that they provide services for the BAME community. This does not imply that other services listed on this table do not provide services for the BAME community.
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[Diagram showing a timeline with stages of pre-conception, pregnancy, baby, toddler, and pre-school, with interventions and assessments listed.]
Universal Intervention Programmes in Birmingham

- Pre-conception
- Pregnancy
- Baby
- Toddler
- Pre-school

Continuous Assessment

- Anawim Family Support
- Acacia Family Support
- Malachi Family Support
- Triple P Positive Parenting – Action for Children
- Parent as Partner* – Improve father’s relationship with their child and mother
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