

Young people's mental health in the UK: A 'preventative turn' emerging from crisis

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A national crisis?

A "national crisis" in the UK has been reported in recent years regarding care and support for children and young people's (YP) mental health and emotional wellbeing (Collishaw, Maughan, Natarajan, & Pickles, 2010; Cooper, 2014). Statistics show that 10% of children and YP aged between 5 and 16 have a diagnosable mental health problem including: conduct disorder (6% of the YP population), anxiety disorder (3%), hyperactivity disorder (e.g., ADHD; 2%) and depression (2%) (Mental Health Taskforce (MHT), 2016; ONS, 2004). As many as one in 12 YP are recorded to have self-harmed with 38,000 to the point of being hospitalised in 2015 (Mental Health Foundation, 2006; Young Minds, 2015) and the vast majority of the 1.5 million people estimated to have eating disorders in the UK are likely to have presented symptoms before their 20th birthday (Beat, 2015).

Other social and demographic factors are associated with increased risk of mental ill-health in YP. For example, children and YP from areas of socio-economic deprivation are three times more likely to present symptoms of mental ill health than those from more affluent areas (MHT, 2016). 95% of imprisoned young offenders have a mental health disorder and are far more likely to experience Autistic Spectrum Difficulties compared to the general population (15% compared to 0.6-1.2% respectively). More generally, YP diagnosed with conduct disorder (e.g., disruptive and

aggressive behaviour) are significantly more likely to leave school without qualifications, three times more likely to become a teenage parent, and up to four times more likely to become 'drug dependent' (MHT, 2016).

This "national crisis" not only reflects increasing and highly complex mental health needs among YP but also the inadequacies of a system ill-equipped to support YP and their families. In fact the majority of children and YP who have a diagnosable mental health problem are unlikely to receive any support, and those who do will typically wait up to 32 weeks for routine appointments for psychological therapy (MHT, 2016). Moreover, YP requiring acute inpatient psychiatric/ psychological support are likely to need to travel long distances to specialist health facilities in neighbouring cities or further afield (MHT, 2016).

Whilst inadequate mental health provision plays a crucial role in the "national crisis", there are other important contributing factors. The stigma associated with mental illness creates a major barrier to accessing services and support. The "Talking Taboo" report (Young Minds, 2012) demonstrated that only 10% of YP felt comfortable seeking advice from a GP, teacher or parent about the issue of self-harm; a finding compounded by the admission of approximately 1/3 of parents who indicated they would not seek professional help in the face of their child self-harming because of concerns about how the problem reflected on them as parents. A further challenge, and one likely to be exacerbated by stigma, is the failure to identify and respond appropriately to early signs of mental ill health. The report "Nobody Made the Connection" (Hughes, Williams, Chitsabesan,

Davies, & Mounce, 2012), demonstrates the negative impact of failing to identify and address YP's mental health needs at an early stage, particularly neurodevelopmental conditions (such as ADHD, Autistic Spectrum Disorders or Speech and Language Difficulties). If we add into the mix the reported profound inequalities within the UK in acknowledging and meeting the culturally diverse mental health needs of different communities combined with the dramatic regional variation in service commissioning priorities and resourcing, we can begin to appreciate the gaping holes in children and YP's mental health provision (Wilkinson & Pickett, 2009; Friedli, 2009).

A 'preventative turn'

In the UK there is broad consensus on how the "national crisis" has evolved; a culmination of increasingly complex and significant needs (Collishaw, Maughan, Natarajan, & Pickles, 2010; Mental Health Taskforce, 2016) and woefully insufficient past expenditure on mental health services (Fonay, 2014). Being able to generate a cross party political consensus on the need for increased funding for YP's mental health during the 2015 general election (Young Minds, 2014), despite campaigning within the economic paradigm of "austerity", goes some way to illustrate the extent to which the "crisis" is acknowledged. At the same time, there is a collective understanding about the need to intervene earlier and in a more preventative manner (O'Keeffe, O'Reilly, O'Brien, Buckley, & Illback, 2015) if we are to reduce morbidity (and mortality) associated with mental health in the young. However, services are stretched beyond capacity and consequently face severe challenges to adequately support children and YP.

One major challenge for Child and Adolescent Mental Health Services in the UK is YP 'failing to engage' with services and being prematurely

discharged as a result (Roy & Gillett, 2008). Campaigns such as Time-to-Change (<http://www.time-to-change.org.uk>) are creating opportunities to challenge public stigma surrounding mental health, but providers also need to ensure they offer YP and their families services which are sufficiently meaningful, inclusive and non-stigmatising. Recognising that the contexts within which we seek to meet the mental health and emotional needs of children and YP are as much political and economic as they are social and psychological suggests a move towards a perspective of practice that is more embedded within "community". Moreover, we need to conceptualise community in its widest sense. For example, for many YP, community is not just about their local surroundings and links through family and friends, but it is also constituted online and via social media. Prevention and support initiatives must therefore be firmly embedded within the online and social media community.

In the face of current failings in mental health support and services for YP, and in the realisation that an effective response to growing needs is unlikely to ever be sustainable through crisis reactive models of practice and provision alone, there is a 'preventative turn' beginning to emerge in the UK (e.g., MHT, 2016). A growing body of participatory and innovative initiatives are being piloted and implemented which aim to address mental health prevention and support in engaging, timely and flexible ways (e.g., HeadStart, YoungMinds, CUES-Ed, & Bounce Back). CUES-Ed (<http://cues-ed.co.uk/>), for example, is a classroom based initiative targeted at primary school children who are introduced to 'emotional resilience' and 'efficacy building' through age adapted forms of CBT. 'Young Minds vs' series of campaigns (<http://www.youngmindsvs.org.uk>), on the other hand, are aimed at 'resilience building' initiatives for older children in relation to important challenges faced at school and beyond; including bullying, sex and relationships, school

stress, employment and access to services. Moreover, outside of the classroom, and in the wider conceptualisation of prevention and 'community', more exclusive online resources are being implemented through the development of engaging digital tools. For example, APPs are emerging to include:

- doctor consultations
(<http://www.docready.org>)
- information about medications
(<http://www.headmeds.org.uk>)
- talking about feelings and mood
(<https://moodbug.me>)
- counselling
(<https://www.kooth.com>)

as well as accessible, anonymous and 'safe' online peer support (e.g., <http://www.silentsecret.com>).

Early indication is that YP are engaging with online and other preventative resources and 'communities', and that learning and skills development is evident (Hart & Heaver, 2015). However, a stronger evidence-base is undoubtedly needed. For example, while YP may be engaging with online 'resilience building' initiatives, which ones are the most effective, and what impact do they have on longer term mental health difficulties and the uptake of secondary mental health resources (Hart & Heaver, 2015)? Moreover, as Friedli (2009) and others have argued, there is a need to elevate 'resilience' and 'efficacy building' from an 'individual focus' to one that embraces the wider economic, health and social which contextualise 'mental health', 'agency' and 'resilience' e.g., 'building resilience' should not excuse our collective duty to improve the social, educational and economic determinants which are likely to exacerbate poor mental health and wellbeing. Nevertheless the emergent 'turn' from a predominant and inadequate crisis-resolution mental health provision, to one which is more equipped and focussed on prevention and engagement in YP appears to be an important opportunity which has surfaced from "crisis".

Conclusion: From crisis to opportunity

A recent independent review (Mental Health Taskforce, 2016) highlighted many of the weaknesses in current mental health services for YP and their families and offered a clear framework for transformation of services over the next 5 years. The concern remains that whilst we are seeking to address a chronically underfunded area of need, as well as improve what is actually on offer, funding cuts to much-needed services and support undermine their ability to function productively. We have discussed a 'preventative turn' in the UK where a number of innovative interventions designed to build 'emotional resilience' are emergent out of the "crisis"; albeit with 'individualistic' focus. Building on the opportunity this affords, we propose evidenced-based 'community' and participatory preventative strategies will go a long way to address the gaping shortfalls that exist in Children and YP mental health services in the UK.

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