



Vulnerable young people HeadStart



Introduction

HeadStart is a £67.4 million National Lottery funded programme set up by The [National Lottery Community Fund](#), designed to test new ways to improve the mental health and wellbeing of young people aged 10 to 16, and prevent serious mental health problems from developing. HeadStart understands that the mental health and wellbeing of children and young people is shaped by experiences in different aspects of their lives, including at school, at home, in relationships with family and peers, interactions with digital technology and within broader mental health systems. In collaboration with schools, families, universities, charities, voluntary and community organisations (VCOs), public and clinical services, and young people themselves, HeadStart aims to:

- Build young people's emotional resilience
- Respond to the early signs of common mental health problems
- Provide joined-up, cross-organisational support when and where it is needed.

The programme has implemented a range of universal, evidence-based interventions to meet its aims, and involves six local authority partnerships identified as having higher levels of social and economic deprivation than the national UK average. These are:

- Blackpool
- Cornwall
- Hull
- Kent
- Newham
- Wolverhampton

In addition to their universal programmes, each partnership has also provided targeted support services and interventions for young people experiencing at least one particular 'vulnerability'. This helps HeadStart provide more specialised and targeted support to young people whose mental health is, or may become, affected by a particular personal, social and/or economic disadvantage at the same time as offering programmes that all young people can engage with and benefit from.

What is a vulnerable young person?

Public Health England's [No Child Left Behind: Understanding and quantifying vulnerability](#) acknowledges that there is no commonly shared definition of a 'vulnerable young person'. The report defines vulnerable children as *'any children at greater risk of experiencing emotional or physical harm and/or experiencing poor outcomes because of one or more factors in their lives'*.¹ A child or young person could therefore be classified as 'vulnerable' in relation to socioeconomic status; latent psychological vulnerability;² sexual, gender and racial identity; special educational needs and disabilities (SEND); chronic, life-threatening and/or stigmatised health problems; domestic abuse; insecure housing; bereavement and criminal exploitation, amongst many others.

A young person with a single vulnerability or multiple vulnerabilities may be more likely than a non-vulnerable peer to experience mental ill-health, bullying, social isolation, low self-esteem, poor physical health and reduced academic attainment, however the relationship between vulnerability, a young person and any one of these outcomes is complex.

Childhood vulnerability can emerge due to dynamic, shifting and interrelated interactions between the child or young person's family and social environment, individual psychological disposition, genetic makeup and broader socio-political context. The ways in which these vulnerabilities are addressed and supported can have a significant impact on whether a young person experiences a negative outcome in relation to their vulnerability, or not.

In a survey of over 30,000 young people in 2018, the HeadStart Learning Team, based at The Anna Freud National Centre for Children and Families, found that 18.4% of young people aged 11–14 reported experiencing emotional problems and 18.8% stated that they were exhibiting behavioural problems in school.³

The study discovered that the likelihood of experiencing either an emotional or behavioural problem was significantly increased in children who were eligible for free school meals (FSM), had special educational needs or were classified as a 'child in need', whom is defined as any child '*unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services, or a child who is disabled*' (Children Act 1989).⁴

These findings sit within a large body of research concluding that children eligible for FSM (Deighton et al, 2019), children in need (Deighton et al, 2019),⁵ and those with SEN (Rose et al, 2009)⁶ are more likely to experience an emotional or behavioural problem, alongside children of Black and Minority Ethnic (BME) identity (Memon et al, 2016),⁷ children living in poverty (Jakoljevic et al, 2016),⁸ children with caring responsibilities (Gray et al, 2008)⁹ and/or those with a parent suffering from a mental illness (Van Loon et al, 2014).¹⁰

Gender is also found to be an influential factor in the development of emotional and behavioural problems, with female gender correlating with higher incidence of emotional problems and male gender with behavioural problems (Zahn-Waxler et al, 2008).¹¹ These findings demonstrate that there are particular groups of children at higher risk of developing mental ill-health and wellbeing amongst an overall population of children globally whose mental and emotional health needs are increasing, which has led to what many have described as a child and adolescent mental health crisis (The Lancet,



2020;¹². Royal College of Psychiatrists, 2021;¹³ NHS Confederation, 2021;¹⁴ American Psychological Association, 2022).¹⁵

Despite these findings, research also shows that many things can be done to improve the mental health and wellbeing of vulnerable children and young people. Numerous studies cite the importance of early intervention in the prevention of emerging mental health difficulties and treatment of diagnosed mental disorders (Craig et al, 2004;¹⁶ Petersen et al, 2005).¹⁷ As 75% of mental health disorders emerge prior to the age of 25,¹⁸ many official guidelines (IRIS,¹⁹ DfE's Mental Health Policy Implementation Guide,²⁰ STEP)²¹ emphasise the importance of 'youth friendly' early intervention services and approaches that promote the creation of 'cultures of care' which are able to provide specific interventions for a range of syndromes and comorbidities in young people (IRIS, 2012:2).

Numerous studies demonstrate the positive impact that social prescribing has on mental health and wellbeing (Leavell et al,²² 2019; Dayson et al, 2020;²³ Chatterjee et al, 2018)²⁴, and emerging studies find that it can have positive impacts on the wellbeing and resilience of children and young people (Efsthathopoulou, 2020)²⁵ and of people from disadvantaged communities in particular (Hassan et al, 2020).²⁶ Providing services at different levels of universal, targeted and specialist intervention is also shown to promote positive mental health in young people by providing a step-up-step-down approach to mental healthcare (Ngo et al, 2020).²⁷

This means that those using mental health services are able to continue to receive mental health support after they are no longer in need of specialist services, and are able to remain in the mental healthcare 'system' in a way that supports their individual level of need.

What is HeadStart's role in supporting vulnerable young people?

The programmes of the six HeadStart partnerships adopt a preventative approach to children and young people's mental health and wellbeing with the aim to intervene as early as possible to help prevent more serious mental health problems from developing. HeadStart promotes whole-system approaches to mental health and wellbeing, and partnerships train and up-skill professionals from across the community to embed holistic mental health practices on whole community and whole school levels to give young people the best chance at receiving the right support at the right time.



Being young-people led, HeadStart services promote a culture of care whereby children and young people are embedded throughout service design, delivery and evaluation, and all young people receiving mental health and wellbeing support through its programmes are also welcomed and encouraged to co-produce as well. This helps to create and sustain services that are truly young person-centred, caring and empowering across all levels. Young people are invited to receive support from HeadStart at any time, regardless of whether they have received specialist mental health support previously or whether they have already engaged with HeadStart services, and each partnership works with communities to promote social prescribing approaches that support young people through a collaborative, multidisciplinary network as well as making best use of resources in each local authority area. This provides young people with a supportive net which underpins the targeted programmes on offer from each partnership to support with specific vulnerabilities.

Blackpool

[HeadStart Blackpool](#) have established [Friend for Life](#) (FfL), a befriending scheme that links a Looked After Child in Blackpool with a caring, trusted, HeadStart-trained adult to build a long-lasting friendship for life. Between September 2019 and August 2020, 25 adult volunteers had received over 450 hours of training to participate in the scheme, and 13 group activities were provided by HeadStart for young people and trusted adults, including trips to local attractions, shared celebrations around Christmas and arts and crafts events to attend together (HeadStart Blackpool, 2020).²⁸

Looked After Children

More likely to have grown up in poverty, where they are more likely to be affected by social and school exclusion, insecure housing and poor nutrition

More children in poorer areas of the country, where there are high levels of poverty and social deprivation.

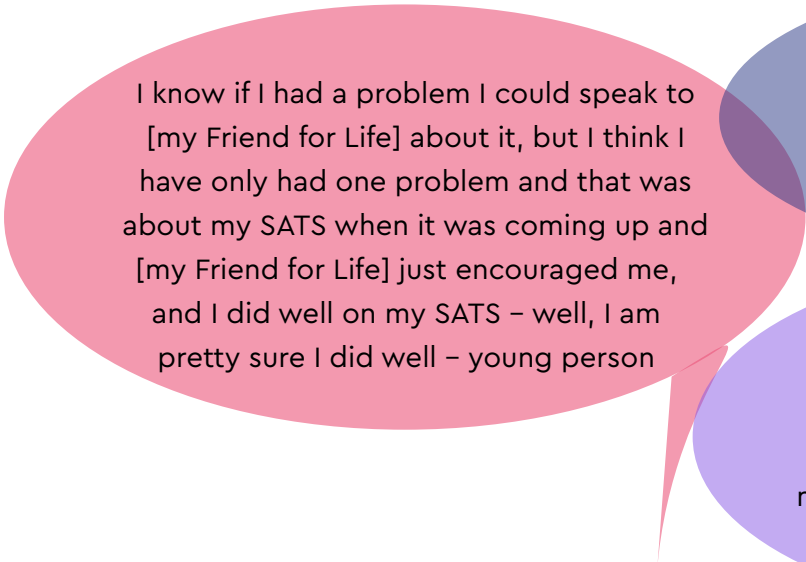
More vulnerable to developing mental health problems earlier in adolescence and childhood.

Up to five times more likely than the general population of children to develop a mental health problem.

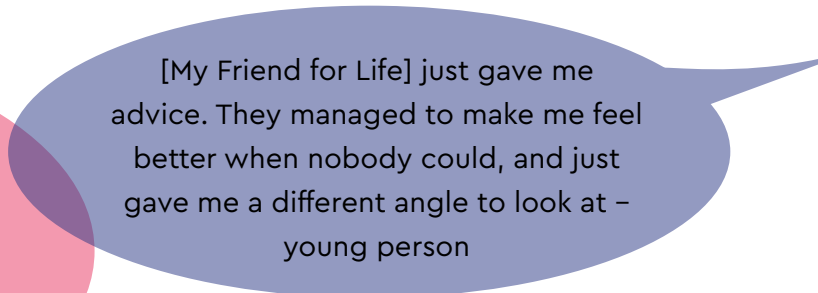
Figure 1 – Looked After Children. References from top left, clockwise to bottom left: (Spencer, 1996);²⁹ (Lai et al, 2019).³⁰ (Richardson, Joughin, 2000);³¹ (McCann et al, 1996;³² Arcelus et al, 1999);³³ (Blower et al, 2004),³⁴ and (McAuley, Young, 2006).³⁵

Looked After Children – described by Blackpool Council as 'Our Children' – are children and young people who have been under the care of their local authority for more than 24 hours. Research demonstrates that positive relationships with trustworthy, caring adults can support, empower and enable Looked After Children to thrive, (Forrester et al, 2009:439).³⁶ Friend for Life was [originally developed by Professor Angie Hart](#) from the [Boing Boing Community](#) to address these inequalities, and is inspired by [research](#) around the importance of significant adults in the lives of Looked After Children. The FfL scheme empowers young people aged between 10 and 12 to build a relationship with a trustworthy adult by giving them the choice of who they would like to be matched with. In the first three years of delivery, 18 friendship matches had been facilitated and all of these 18 had continued. Young people were subsequently interviewed by HeadStart Blackpool so that they could learn about the impacts that the scheme had on their lives, mental health and wellbeing. They found that, collectively, the young people reported fewer negative influences and more positive influences in their lives over the first year with their FfL, as well as improved self-confidence (HeadStart Blackpool, 2020).³⁷

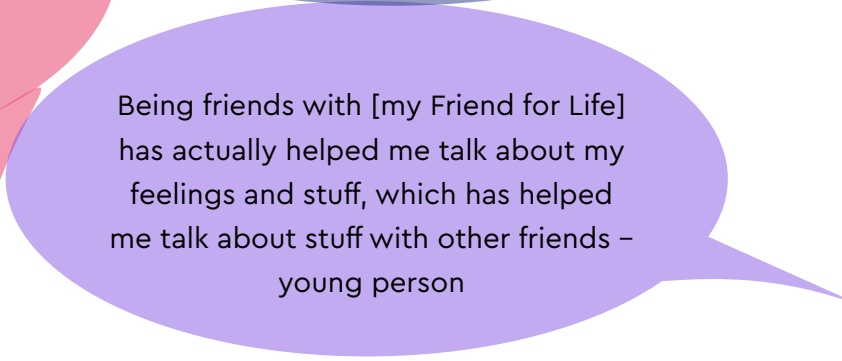
Young people who had been matched for one year or more also demonstrated reduced incidences of fixed-term exclusions for 1.2 days on average, an increase of 6 days in school per year and no permanent exclusions.



I know if I had a problem I could speak to [my Friend for Life] about it, but I think I have only had one problem and that was about my SATS when it was coming up and [my Friend for Life] just encouraged me, and I did well on my SATS – well, I am pretty sure I did well – young person



[My Friend for Life] just gave me advice. They managed to make me feel better when nobody could, and just gave me a different angle to look at – young person



Being friends with [my Friend for Life] has actually helped me talk about my feelings and stuff, which has helped me talk about stuff with other friends – young person

Cornwall

This section contains information about sexual abuse, violence and exploitation against children which readers may find upsetting.

[HeadStart Kernow](#) offers targeted support to children and young people with higher levels of mental health need through its [Youth and Community Facilitators](#), who provide holistic 1-1 interventions to children and young people aged 10–16 who are vulnerable to exploitation across Cornwall. Youth Practitioners are enrolled on an enhanced safeguarding training package to provide them with the skills and knowledge to support young people affected by or at risk of different types of exploitation and most vulnerable to developing a mental health problem. Data from Devon and Cornwall Police shows that Cornwall has high and increasing rates of child sexual exploitation (CSE) and child criminal exploitation (CCE),³⁸ particularly through county lines drug trafficking. CSE is a form of sexual abuse that occurs when one person uses their power over a young person under the age of 18 to sexually

abuse and exploit them (Gov, 2016), and county lines refers to the exploitation of children and young people by adults and organised gangs, who use them to distribute illegal drugs. Devon and Cornwall Police have shown that harmful sexual behaviours perpetrated against young people, particularly girls but also boys, are increasing, and although sexual abuse and exploitation is under-reported, 470 children were nevertheless identified as at risk or experiencing CSE in 2019, and 670 sexual offences were reported to the police (Cornwall Council, 2020).³⁹

Child sexual exploitation

Includes, but is not limited to, sexual violence, filming sexual acts, sharing indecent images of children and sexualised conversations.

Children are often tricked into believing that they are in a consensual relationship with the person abusing them.

Perpetrators target vulnerable children, and being a victim of CSE also increases vulnerability, such as to developing mental health problems (NSPCC).

Children may be given things like money or 'gifts' in exchange for sexual acts or to prevent them from disclosing the abuse.

They also report a continued spread of organised drug trafficking from major cities into towns and villages in Cornwall, with growing numbers of young people being exploited through county lines networks (ibid). Due to the size and rurality of Cornwall, in addition to offering one-to-one support, HeadStart Kernow tackle child exploitation by building a protective network of communities and partners across the county, and this strand of the work is led by the Community Facilitators. This helps to protect vulnerable young people by offering collaborative, joined-up support across localities, organisations and services.

Cornwall Youth Facilitators conduct 1-1 interventions with young people in school or community-based settings and aim to help them:

- Manage their feelings effectively
- Form positive, healthy relationships
- Form positive peer group relationships and social connections
- Develop effective planning and problem-solving skills
- Develop effective life and organisational skills
- Develop effective decision-making skills

They work with community groups and parents to build knowledge and skills around working with young people in a way that supports their mental health, and link young people with services and

organisations that could develop their interests and help protect them from harm. Youth Facilitators are given training in trauma-informed approaches and the [PACE](#) (Play, Acceptance, Curiosity and Empathy) model developed by [Dr Dan Hughes](#) to support them to be calm, containing and emotionally regulated for the young people they work with. They use the [My Mind Outcome Star](#) to facilitate conversations with the young person, which adopts a 'Journey of Change' approach to empower them to learn what helps them to emotionally regulate so that, eventually, they can manage their wellbeing independently.

I know that I can do this now and know that I can have a future. I think I've made good progress and feel I can start meeting my friends more and get back to school – young person

Since the Youth Facilitator support was launched by HeadStart in 2018, demand for the service has remained high. Referrals to the service have shown increasingly complex and higher-levels of need, with many young people requiring more specialist mental health support and/or experiencing multiple difficulties in their lives that were contributing to worsening mental wellbeing. To overcome this challenge, the service changed its referral process so that all applications were processed through [Bloom](#), a multi-agency team who come together to discuss a young person's case and establish a holistic package of support for them, drawing on services in the community and voluntary sector provisions.

The Youth Facilitators support vulnerable young people at-risk of exploitation around forming positive peer group relationships, positive and healthy relationships and managing feelings effectively. The interventions are evaluated with pre and post measures analysis of My Mind Outcome Star data, which is broken down into eight measures including friends and relationships, safety, home and family and emotional wellbeing. An analysis of 25 young people during the pilot stage of the service found that 72% reported an improvement in their emotional wellbeing, 60% saw improvement in their relationship with school, training or work; 52% reported improvement in friends and relationships and 28% reported improvement in safety (with 56% seeing no change) (HeadStart Kernow, 2020).⁴⁰ As of 2020, 296 young people had completed a 12-week intervention with a Youth Facilitator, 41 had begun but not finished the intervention, and 120 young people were receiving support as they entered 2021.

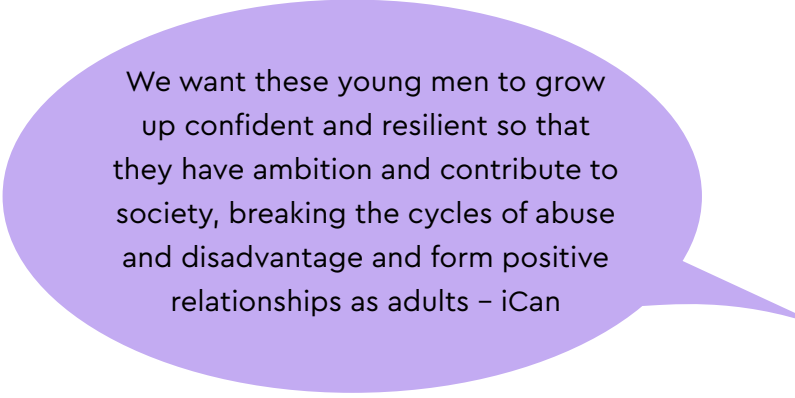


Kent

HeadStart Kent have funded iCan, a trauma-informed service for boys aged 13–16 who have witnessed or experienced domestic violence.

The [iCan](#) programme mentors boys one-to-one and in groups over the course of 24 sessions to promote mindfulness, self-care and healthy relationship-building in a safe setting. The central aim of the programme is for the young people to develop their resilience so that they can build a greater capacity to defend against the adversity associated with domestic violence in childhood.

The progress of young people is evaluated through three quantitative measures: the young person's CORE, [shortened Warwick Edinburgh Mental Wellbeing Scale](#) (WEBMWS) and [Resilience Conversation tool](#), as well as ongoing qualitative feedback from young people, families and schools.



We want these young men to grow up confident and resilient so that they have ambition and contribute to society, breaking the cycles of abuse and disadvantage and form positive relationships as adults – iCan

The iCan programme recognises that a violent home significantly increases a young person's risk of developing serious mental health problems, and that boys are at an increased risk of communicating their distress through externalising and aggressive behaviours, which substantially increases their risk of suffering peer violence (HeadStart Kent, n.d.).⁴¹ iCan aims to address these risks through a trauma-informed and gender specific programme delivered by a male mentor, that empowers the young person by providing them with the decisions of what they focus and work on throughout the programme, where the sessions take place and what changes they would like to see in themselves and their lives by the end of their engagement.

Domestic violence

Children who witness or suffer domestic violence face increased vulnerability to psychosocial impairment and mental ill-health.

Boys who grow up in households with domestic violence are more likely to display externalising reactions and behaviours in response to violent trauma.

Boys who witness or are victims of domestic abuse in childhood are more likely to be criminally exploited and engage in violent offending.

Boys exposed to domestic violence in childhood are at an increased risk of perpetrating domestic and peer violence in later life.

Figure 4 – Domestic Violence Figure 4 – Domestic Violence – References clockwise, from top left to bottom left: (Ellonen et al, 2010; Arnow, 2004; Schilling et al, 2008; Cater et al, 2015), (Orr et al, 2020), (Jung et al, 2019; Stith et al, 2000; Whitfield et al, 2003; Bevan et al, 2002; Chen, White, 2004), (Fix et al, 2018; Farrington, 1991; Farrington, 1995; Herrenkohl et al, 2020).

The programme is structured around [the 6 resilience domains](#) developed by Daniel and Wassel (2002),⁴² which were used to create the six areas of resilience that underpin the iCan programme. These areas serve as a guide and a tool to help the young person and their mentor to think about areas of their lives that are going well, and those that may benefit from some therapeutic input and active changes. These are:

- Feeling secure – how secure young people feel in themselves and with the people around them
- Education – learning and trying new things, receiving support to do so
- Talents and Interests – accessing enjoyable or new activities that they may be interested in or want to try
- Emotions and behaviours – being able to manage difficult emotions and behaviours and feel positive about the future
- Health – physical health and wellbeing and those of the people around them
- Friendships – having and making new friends, being a good friend and having a supportive network

Young people work with their mentor to establish which of these domains present lower levels of resilience in their lives, and agree upon an action plan to improve resilience in these areas. The programme has a range of short- and long-term intended outcomes, and desired societal impacts. Short term outcomes include greater understanding of safe and non-coercive relationships, and an increase in self-acceptance, confidence and resilience. Long-term outcomes include for the young people to learn and practice more positive ways of coping with their emotions and behaviours, increasing their engagement with education and improved relationships with family members, peers and their communities. Broader systemic impacts are for adolescent boys to have improved aspirations and life chances, reduced costs to society in terms of healthcare and the criminal justice system, and reduced risks of offending, violence and further victimisation.

We believe their [the young people's] needs are often overlooked when the adults around them are in crisis, but also during the recovery phase, and that the representation of their suffering may become associated with perceived 'male-hood' rather than their experiences – iCan



As of November 2021, 213 boys of an average age of 14.4 had taken up support from iCan.

123 of these young people completed the support in a planned way, and 111 of those had their wellbeing measured before and after the support using WEMWBS.'

The average pre-intervention score was 46.6, and the average post-intervention score was 55.25 – an increase in wellbeing of 18.56%, which is a significant increase.'

80% of the young people were from White backgrounds, 12% were from BAME backgrounds and the remaining 8% were unknown.

33% of referrals came from schools, 28% from Early Help, 17% from VCOs, 12% from social workers and 10% from either CAMHS, youth offending services, parents or young people themselves.

Hull

[HeadStart Hull](#) provide an extended offer of support for parents and carers across Hull, with one of its three parenting services, [KIDS](#), providing support to parents and carers of children and young people aged 5–16 with a disability. The service aims to support the mental health and wellbeing of parents, carers and children through training delivery and advice and multi-agency collaboration with other organisations, services and families to deliver HeadStart Hull's aim of developing 'stronger family networks'.

Parents of children with disabilities are shown to face social, economic and financial difficulties which can put pressure and strain on parents (Tigere, Makhubele, 2019).⁴³ Studies have shown that, without the right support, parents of children with SEND are at greater risk of experiencing stress and anxiety,⁴⁴ depression,⁴⁵ and other mental and emotional health problems,⁴⁶ and poor parental wellbeing is known to have adverse effects on the mental health and wellbeing of children (NSPCC, 2021)⁴⁷. Social support, meanwhile, has been found to improve the mental and physical wellbeing of parents and carers of children with a disability, and the overall quality of life for all the family (Heiman, Berger, 2008).⁴⁸

KIDS deliver group work across Hull as well as one-to-one support for parents who want to attend the workshops but whose children do not have a formal SEND diagnosis. They provide an extended offer of support for parents, including:

- Long term training courses including Stepping Stones and Teen Life for parents and carers of young people age 10 to 16 years on the autism spectrum
- Autism Spectrum Condition workshops for parents

- Family Start support to all families attending longer term courses
- Autism Spectrum Condition workshops for professionals
- Triple P online training and resources for parents of children with multiple disabilities
- Workshop delivery with the Sleep team clinic

KIDS helps parents to understand SEND, which includes educating them on some of the triggers prompting challenging behaviour and understanding what the behaviour may be trying to communicate. It teaches parents supportive strategies to help them help their children manage their own behaviour, and to implement healthy boundaries at home. It adopts a compassionate stance and encourages parents to be empathetic towards themselves when supporting and trying to understand the behaviours and feelings of their children.

The KIDS programme is evidence-based, and co-produced between [SENSE](#) and parents and carers of children with disabilities and special educational needs. From April 2020 to March 2021, KIDS supported 310 families through a combination of one-to-one support and group work, and the

Thank you so much for helping me to understand my daughter better. It really has changed everything for our family. I feel a lot more connected with my daughter and I hope she feels the same. I now am able to accept who she is and I love every bit about her. We can now see that we need to adapt things for her rather than just 'push' her through things – a parent.

It helped me understand what my daughter needs and to watch her in different situations to what might cause her later on to have a melt down and knowing how to talk to her without over stimulating her brain in melt down stage and overall give me better view of her in general – a parent.

presenting issue for 236 of these families was speech, language and communication needs, followed by Autism Spectrum Condition (ASC). The service is evaluated through the [Family Star](#) outcomes assessment tool, which measures progress in the following areas:

- Physical health
- Emotional wellbeing
- Keeping your children safe
- Social networks
- Education and learning
- Boundaries and behaviour
- Family routine
- Home and money

Pre and post outcomes evaluation of Family Star data shows consistent improvements across different areas. A sample of 203 families completing the Family Star before and after receiving support from KIDS showed that all 203 families reported improvement in a minimum of 1 area, 71% showing improvement in at least 2 areas and 57% showing improvement in at least three areas. Feedback

evaluation from 40 parents and carers showed that 100% of course attendees felt more confident after receiving support from KIDS, and felt that the information they received would support the needs of the whole family.

Newham

HeadStart Newham run Your Time, a befriending service that was set up to tackle loneliness and social isolation after school closures in the March 2020 Covid-19 lockdown. Your Time connects a young person with a HeadStart-trained Youth Practitioner to provide the opportunity for meaningful social connection, a place to share worries and feelings, and advice and guidance on strategies that improve wellbeing and reduce anxiety. Youth Practitioners signpost young people to community activities and events, share online resources that support positive mental health and wellbeing, promote physical health and exercise, and continue to deliver resilience-based HeadStart interventions over virtual platforms and face-to-face in schools and communities. Although the service was set up and launched after March 2020 and in response to the lockdown, it was designed in collaboration with the [Youth Empowerment Service](#) and [Newham Children and Young People's Commissioning](#) prior to the arrival of the pandemic, and was intended as a face-to-face intervention for vulnerable young people in schools and communities. As the pandemic greatly exacerbated loneliness and isolation for all children and young people, and posed even greater challenges to mental health and wellbeing for those most vulnerable, the service was welcomed as a timely and appropriate response to these challenges.

Your Time is available for any young person aged between 5 and 18 years, and up to 25 years for young people with SEND. One-hour, weekly sessions run over a period of 12 to 18 weeks for young people over the age of 10 by HeadStart Youth Practitioners, and, for children under 10, the service is delivered by the [School Health Team](#) over a shorter time frame. Children and young people are matched with Youth Practitioners based upon skillsets, interests and experience in working with young people affected by particular issues, such as SEND or particular emotional and mental health needs. Swift implementation of the project was enabled by HeadStart Newham's established and strong links with community services, and its own extended support offer for children and young people. This has led to effective, prompt and smooth support for young people through Your Time, as Youth Practitioners have been able to draw upon their local knowledge and experienced delivery across other HeadStart programmes.



You have helped me because I feel like I can't speak to my teachers, like Miss, because I don't feel comfortable with her, I don't feel comfortable with them. But you can talk for me because I'm really anxious. I feel like counselling [Your Time] to me is about my problems and I don't want to talk about school and my problems with Miss or a teacher, only my counsellor [Youth Practitioner], and I can talk to you about school and everything – young person.

- Main reasons for referral
- Mood difficulties
- Loneliness and isolation
- Bullying
- Behaviour problems

Your Time enables Youth Practitioners to get to know young people over a generous time period, which means that they have been able to offer individualised and longer-term support. Youth Practitioners are also able to work flexibly and creatively to help young people in different ways, ranging from emotional to practical support. For example, they have:

- Offered practical support around housing, helping to move young people who are vulnerable where they currently live and into another borough where they are safe and secure.
- Helped young people to express their emotions verbally as opposed to demonstrating how they feel through disruptive behaviour in school, providing them with the vocabulary that they didn't previously have to put names to their feelings.
- Helped young people to understand and recognise positive and negative relationships, and how to build healthy friendships.
- Educated young people in sleep hygiene and helped them increase the quality and length of their sleep each night.
- Supported young people and families by working with the family unit as a whole, leading to increased time spent together on weekends and less disruption and conflict in the family home.

I definitely believe and saw first-hand that your Youth Practitioner support helped my son with his confidence and boosted his self-esteem to be able to perform on stage the way he did – parent of a young person who engaged with Your Time.

Thank you for all you are doing, you [Youth Practitioner] are a great asset to the HeadStart team and the young people. You are making a positive difference to their lives – parent of a young people with SEND, supported in the first lockdown through Your Time.

I like meeting with you because I can come out of class and talk about what's been going on in my week. I don't really like school but I look forward to Thursday and meeting up with you. You help me with my lunch fast tracker which has helped me along the way, thank you – young person

The COVID-19 Pandemic has exacerbated inequalities in health, mental health and social connection for children young people and families in Newham. Your Time has led to lower risk of isolation and exclusion, and support to young people with SEND (25% of caseload diagnosed or awaiting diagnosis). It has enabled Youth Practitioners to understand and validate their needs and the challenges they have faced during the pandemic. The service has enabled young people to continue to connect, build new relationships with trusted adults during a difficult period, which enabled development of young people's trust in professionals, and provided a dimension of support that school staff were unable to offer during a time when it was most needed.

- 257 referrals received between March 2020 and September 2021
- Ethnicity breakdown: 28% Asian, 22% Black, 19% White, 8% , Mixed Race, 7% AOEG, 16% not obtained
- 61% female and 39% male
- 79% aged between 12–17, 12% under 10, 9% 18–21
- Top 5 referring agencies are schools, HeadStart, CAMHS/Newham MAC, Early Help and Social Care



Wolverhampton

In 2018, [HeadStart Wolverhampton](#) commissioned a local, community-based and [award-winning](#) independent organisation called [Positive Participation](#) to promote the mental health and wellbeing of Asian children and their parents through culturally-attuned hospital, community and school-based interventions. This partnership has led to the delivery of culturally-specific mental health awareness days, assemblies and workshops in schools across the city, which were designed to tackle stigmas and misunderstandings surrounding mental health that were found to be specific to the cultures of the pupils in the schools and, in some cases, their parents and families. These services and interventions have been aimed at Asian children in particular (although the organisation also supports other Minority Ethnic as well as White children, young people and families) due to the recognition of mental health inequalities that exist between Black and Minority Ethnic (BME) and White children and young people, and the demographics of Wolverhampton.

As of 2011, 32% of Wolverhampton's population belonged to Black or Minority Ethnic backgrounds, and the largest ethnic group within this broad category was Indian, at 12.9% of the overall population (UK Census, 2011).⁴⁹ This stands in contrast to the rest of England, where only 2.5% of the population are Indian and 13.8% are of the broader 'BAME' category (Diversity UK, n.d.)⁵⁰. Research finds that children from BME communities are underrepresented in CAMHS, but overrepresented in adult mental health inpatient services (Malek, Joughin: 2014).⁵¹ Adolescent South Asian girls, for example, are found to be more likely than White Caucasian girls to self-harm, but less likely to attend A&E for their mental health (Lavis, 2014)⁵², and research also finds that children and young people from minoritised communities are less likely to seek support outside of the family unit for problems with their mental health (Street et al, 2005)⁵³. They may also face barriers that White children are less likely to face when needing mental health support, such as a lack of culturally relevant and specific services (Malek, 2011).

I'm seeing too much delivery that is euro-centric. It needs to be culturally adapted to make any sense to them [young people from BAME communities]. It has to be delivered in a way where communities have established trust in order to engage [...] you take professionals who are from those communities, you go into the schools and those areas, and that's how you would engage with those communities on mental health. [...] Mental health first-aid is no good if it's not culturally adapted. – Positive Participation

Positive Participation encourage pupils to speak openly about their mental health and explore what it could mean for their lives in the future if they were confident enough to ask for help at an early stage, and are able to talk to someone they can relate to and who is suitably trained and able to respond to their cultural needs. They conduct interventions and workshops in schools and provide young people with the opportunity to qualify as Volunteer Mental Health Ambassadors to offer mental health and wellbeing support to their peers in school. They have also conducted work with schools on racialised hate crime and taught children and young people about what they can do and who they can talk to if they become a victim of hate crime or are worried about violence towards themselves or others.

I want to be a HeadStart mental health mentor to help people in our community – young person.

I think our community needs to talk about mental health because it is a taboo subject and people are really suffering – young person.

The culturally adapted mental health workshop has really helped me to understand what I'm going through. My parents think I am spirit possessed and that someone has put bad luck on our family – young person.

Conclusion

'Childhood vulnerability' is an umbrella term that refers to all the ways that children and young people's mental health and wellbeing, physical health, safety and future prospects are impacted by negative and harmful factors outside of their control. The causes of childhood vulnerabilities are diverse and stem from political, social, economic, interpersonal and individual sources, including, but not limited to, poverty, systemic inequalities, racism, sexism, bullying, disability, parental breakdown and domestic abuse, and genetic predisposition. The targeted programmes of the partnerships address just six examples of childhood vulnerability, but they all evidence the fundamental need for targeted interventions for children and young people facing vulnerability of any kind. There are clear commonalities between the approaches of the partnerships of co-production, child and parent-centred care, and creative, collaborative working across all sectors and agencies in their wider communities. The work of HeadStart has demonstrated that in order for services to be truly innovative and impactful they must become 'cultures of care', involving children and young people at all levels of planning, design, delivery and evaluation, and working as one part of a large, wider community partnership that seeks to continually improve and change in response to the needs, feelings and opinions of young people.

It is vital that the lessons learned from the work of the partnerships continues beyond the end of HeadStart funding in 2022. This learning must be shared widely and its impact demonstrated through clear and robust evaluation that is useful and accessible to everyone working with children and young people, planning or commissioning services, or anyone with an interest in working with young people in the future or developing a new scheme of work. Such learning has been generated by the [HeadStart Learning Team](#) at UCL and The Anna Freud Centre, and the [National Children's Bureau](#) in collaboration with individual teams and services across the HeadStart partnerships. Through sharing information, experiences and outcomes, children and young people can continue to benefit from programmes of support that mitigate the risks posed by growing up in modern times, whilst providing them with the platforms and opportunities to have their voices heard and develop trusting, validating and respectful relationships with adults and services who work to see them develop into happy, healthy and fulfilled young adults.

References

1. Public Health England. (2020). No Child Left Behind: Understanding and quantifying vulnerability. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/913974/Understanding_and_quantifying_vulnerability_in_childhood.pdf.
2. Gerin, M.I., Hanson, E., Viding, E., McCrory, E.J. (2019). A review of childhood maltreatment, latent vulnerability and the brain: implications for clinical practice and prevention. *Adoption and Fostering* 43(3):310–328. Doi: 1177/0308575919865356.
3. HeadStart Evidence Based Practice Unit. (2018). Mental health problems in young people aged 11 to 14: Results from the first HeadStart annual survey of 30,000 children. Retrieved from https://www.ucl.ac.uk/evidence-based-practice-unit/sites/evidence-based-practice-unit/files/headstart_briefing_1_pdf.pdf.
4. UK Government. (1989). The Children Act 1989. UK Public General Acts. Retrieved from <https://www.legislation.gov.uk/ukpga/1989/41/contents>.
5. Deighton, J., Lereya, S.T., Casey, P., Patalay, P., Humphrey, N., Wolpert, M. (2019). Prevalence of mental health problems in schools: poverty and other risk factors among 28,000 adolescents in England. *The British Journal of Psychiatry* 215(3): 565–567 doi: 10.1192/bjp.2019.19.
6. Rose, R., Howley, M., Fergusson, A., Jament, J. (2009). Mental health and SEN: Mental health and special educational needs: exploring a complex relationship. *British Journal of Special Education* 36(1), 3–8. <https://doi.org/10.1111/j.1467-8578.2008.00409.x>.
7. Mohebati, L.M., Sundin, J., Cooper, M., Scanlon, T., Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. *The BMJ Open*, 6:e012337 doi:10.1136/bmjopen-2016-012337.
8. Jakovljevic, I., Miller, A.P., Fitzgerald, B. (2016). Children's mental health: is poverty the diagnosis? *BCMJ Medical Journal* 58(8), 454–460.
9. Gray, B., Robinson, C., Seddon, D. (2008). Invisible children: young carers of parents with mental health problems – the perspectives of professionals. *The Association for Child and Adolescent Mental Health* 13(4), 169–172. <https://doi.org/10.1111/j.1475-3588.2007.00477.x>
10. Van Loon, L.M.A., Van de Ven, M.O.M., Van Doesum, K.T.M., Witteman, C.L.M., Hosman, C.M.H. (2014). The relation between parental mental illness and adolescent mental health: the role of family factors. *Journal of Child and Family Studies* 23, 1201–1214. <https://doi.org/10.1007/s10826-013-9781-7>.
11. Zahn-Waxler, C., Shirtcliff, E.A., Marceau, K. (2008). Disorders of adolescence: gender and psychopathology. *Annual Review of Clinical Psychology* 4, 275–303. <https://doi.org/10.1146/annurev.clinpsy.3.022806.091358>.
12. The Lancet. (2020). Child mental health services in England: a continued crisis. *The Lancet* 395(10222), 389. [https://doi.org/10.1016/s0140-6736\(20\)30289-0](https://doi.org/10.1016/s0140-6736(20)30289-0).
13. Royal College of Psychiatrists. (2021). Country in the grip of a mental health crisis with children worst affected, new analysis finds. Royal College of Psychiatrists. Retrieved from <https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2021/04/08/country-in-the-grip-of-a-mental-health-crisis-with-children-worst-affected-new-analysis-finds>.
14. NHS Confederation. (2021). Generation of children and young people risk not getting the mental health care they need. NHS Confederation. Retrieved from <https://www.nhsconfed.org/news/generation-children-and-young-people-risk-not-getting-mental-health-care-they-need>.
15. Abramson, A. (2022). Children's mental health is in crisis. *American Psychological Association* 53(1), 69. Retrieved from <https://www.apa.org/monitor/2022/01/special-childrens-mental-health>.

16. Craig, TK., Garety, P., Power, P., Rahaman, N., Colbert, S., Fornelss-Ambrojo, M. (2004). The Lambeth Early Onset (LEO) Team: Randomised controlled trial of the effectiveness of specialised care for early psychosis. *The BMJ*. 331:602.
17. Petersen, L., Jeppesen, P., Thorup, A. (2005). A randomised multicenter trial of integrated versus standard treatment for patients with a first episode of psychotic illness. *The BMJ*. 331:602.
18. Kessler, R.C., Amminger, G.P., Angular-Gaxiola, S., Alonso, J., Lee, S., Ustun, T. B. (2007). Age of onset of mental disorders: a review of recent literature. *Curr Opin Psychiatry* 20(4), 359–364. Doi: 10.1097/YCO.0b013e32816ebc8c.
19. IRIS (2012) IRIS Guidelines Update. Iris initiative ltd. www.iris-initiative.org.uk.
20. Mental Health Policy Implementation Guidelines. Department for Health. 2013.
21. NICE Institute for Health and Care Excellence. (2016). Implementing the early intervention in psychosis access and waiting time standard. NHS England. Retrieved from <https://www.nice.org.uk/guidance/qs80/resources/implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard-guidance-2487749725>.
22. Leavell, M.A., Leiferman, J.A., Gascon, M., Braddick, F., Gonzalez, J.C., Litt, J.S. (2019). Nature-based social prescribing in urban settings to improve social connectedness and mental wellbeing: a review. *Built Environment and Health*. 6, 297–308.
23. Dayson, C., Painter, J., Bennett, E. (2020). Social prescribing for patients of secondary mental health services: emotional, psychological and social wellbeing outcomes. *Journal of Public Mental Health*. 19:4, 271–279.
24. Chatterjee, H.J., Camic, P.M., Lockyer, B., Thomson, L.J.M. (2018). Non-clinical community interventions: a systematised review of social prescribing schemes. *Arts & Health*. 10:2, 97–123.
25. Efstathopoulou, L., Bungay, H. (2020). Mental health and resilience: Arts on prescription for children and young people in a school setting. *Public Health*, 198, 196–199.
26. Hassan, S.M., Giebel, C., Khedmati Morsarae, E., Rotheram, C., Mathieson, V., Ward, D., Reynolds, V., Price, A., Bristow, K., Kullu, C. (2020). Social prescribing for people with mental health needs living in disadvantaged communities: the Life Rooms model. *BMC Health Services Research*. 20, 1–9.
27. Ngo, H., Ennals, P., Turut, S., Geelhoed, E., Celenza, A., Wolstencroft, K. (2020). Step-up, step-down mental health care service: evidence from Western Australia's first – a mixed-method cohort study. *BMC Psychiatry*. 20:214.
28. HeadStart Blackpool. (2020). Resilience Revolution Annual Report. Retrieved from www.boingboing.org.uk/wp-content/uploads/2021/03.AnnualReport_201920_final.pdf.
29. Spencer, N. (1996). *Poverty and Child Health*. Radcliffe Medical Press, Oxford, uk.
30. Lai, ETC, Taylor-Robinson, D, Bennett, DL. 'RF26 Quantifying Inequalities in Looked After Children in England', *Journal of Epidemiology and Community Health*
31. Richardson, J., Joughin C. (2000). *The mental health needs of looked after children*. London: Gaskell.
32. McCann, J.B., James, A., Wilson, S., Dunn, G. (1996). Prevalence of psychiatric disorders in young people in the care system. *British Medical Journal*, 313, 1529–1530.
33. Arcelus, J.M, Bellerby, T, Vostanis, P. (1999). A mental health service for young people in the care of the local authority. *Clinical child psychology and psychiatry*, 4(2), 233–245.
34. Blower, A., Addo, A., Hodgson, J., Lamington, L., Towilson, K. (2004). Mental health of 'looked after'

children: a needs assessment. *Clinical Child Psychology and Psychiatry*,

35. McAuley, Young, The mental health of looked after children: challenges for CAMHS provision, 2006.
36. Forrester, D., Goodman, K., Cocker, C., Binnie, C., Jensch, G. (2009). What is the impact of public care on children's welfare? A review of research findings from England and Wales and their policy implications. *Journal of Social Policy* 38(3), 439–456.
37. www.boingboing.org.uk/wp-content/uploads/2021/03/AnnualReport_201920_final.pdf.
38. HM Government. (2016). Statutory definition of child sexual exploitation. UK Government. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/500097/HO_DfE_consultation_on_definition_of_child_sexual_exploitation_-_final.pdf.
39. Cornwall Council. (2020). Cornwall Exploitation Strategy 2020–23 Evidence Base. Retrieved from www.safercornwall.co.uk/crime-in-your-area/documents-and-publications/.
40. HeadStart Kernow. (2020). HeadStart Kernow Learning: Community and Youth Facilitators: Interim Report July 2020. HeadStart Kernow. Retrieved from <https://www.headstartkernow.org.uk/Learning/Revised%20Final%20HSK%20Learning%20Community%20and%20Youth%20Facilitators%20Interim%20Report%20July%202020.pdf>.
41. <https://kentresiliencehub.org.uk/resources/ican-programme/>.
42. Daniel and Wassell, (2002) *Assessing and Promoting Resilience in Vulnerable Children Vols. 1, 2 & 3*, London & Philadelphia, Jessica Kingsley Publishers Ltd.
43. Tigere, B., Makhubele, J.C. (2019). The experiences of parents of children living with disabilities at Lehlaba Protective Workshop in Sekhukhune district of Limpopo province. *African Journal of Disability*. Retrieved from www.scielo.org.za/scielo.php?script=sci_abstract&pid=S2226-72202019000100029.
44. Keenan, B.M., Newman, L.K., Gray, K.M. & Rinehard, N. J. (2016) Parents of Children with ASD Experience More Psychological Distress, Parenting Stress and Attachment-Related Anxiety, *Journal of Autism & Developmental Disorders*, 46:2979–2991, Doi 10.1007/s10803-016-2836-z.
45. Totsika, V., Hastings, R. P., Emerson, E., Lancaster, G.A. & Berridge, D.M. (2011) A population-based investigation of behavioural and emotional problems and maternal mental health: associations with autism spectrum disorder and intellectual disability, *The Journal of Child Psychology and Psychiatry*, 52:1 (2011), pp.91–99 doi: 10/1111/j.1469-7610.2010.02295.x
46. Turk, J. (1996) *Working with Parents of Children Who have Severe Learning Disabilities*, *Clinical Child Psychology and Psychiatry*, SAGE: London, p. 581–596
47. NSPCC. (2021). Parental mental health problems. NSPCC. Retrieved from <https://learning.nspcc.org.uk/children-and-families-at-risk/parental-mental-health-problems#heading-top>.
48. Heiman, T., Berger, O. (2008). Parents of children with Asperger syndrome or with learning disabilities: Family environment and social support. <https://doi.org/10.1016/j.ridd.2007.05.005>.
49. UK Census [online]. (n.d.). Wolverhampton. UK Census, retrieved from <https://www.ukcensusdata.com/wolverhampton-e08000031#sthash.VeiGj7JX.vloWNxB6.dpbs>.
50. Diversity UK [online]. (n.d.). Diversity in the UK. Diversity UK, retrieved from <https://diversityuk.org/diversity-in-the-uk/>.
51. Malek, M., Joughin, C. Eds. (2004). *Mental Health Services for Minority Ethnic Children and Adolescents*. London: Jessica Kingsley.

52. Lavis, P. (2014). Better health briefing: The importance of promoting mental health in children and young people from black and minority ethnic communities. Race Equality Foundation. Retrieved from <http://raceequalityfoundation.org.uk/wp-content/uploads/2018/02/Health-Briefing-332.pdf>.
53. Street, C., Stapelkamp, C., Taylor, E., Malek, M., Kurtz, Z. (2005). Minority Voices: Research into the Access and Acceptability of Services for the Mental Health of Young People from Black and Minority Ethnic Groups. London: Young Minds.



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