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# HEALTHY YOUNG MINDS TRANSFORMING THE MENTAL HEALTH OF CHILDREN

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Report of the WISH Mental Health and  
Wellbeing in Children Forum 2015

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مؤتمر القمة العالمي للابتكار في الرعاية الصحية  
World Innovation Summit for Health



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## FOREWORD

Our children are our future. So, we ignore their mental health at our peril. At least a half of all mental health problems emerge by the age of 18. Yet, even in rich countries, only a quarter of young people in need of help get any specialist treatment, and many fewer in poorer countries. Good psychological treatments exist but they are simply not properly available. This is grossly inhumane and also inefficient.

Mental health problems place massive costs on the rest of society – educational failure, adolescent crime, teenage pregnancy, and ultimately benefit dependence. Moreover, poor mental health disturbs the physical function of the body and leads to major costs in physical healthcare – for example, for psychosomatic complaints, cardiovascular problems and even cancer.

Early intervention is crucial. Mental health problems need to be tackled when they first appear. They need to be recognized by parents, doctors and teachers, and our whole society needs to become much more open and matter-of-fact about what is a common part of life. Our schools need to adopt children’s wellbeing as one of their major objectives – both in their ethos and their teaching. Life skills can and should be taught as professionally as mathematics or literature.

There are solutions to these problems. This report, written with outstanding support from the Forum members, sets out major changes which need to be made worldwide. These changes could revolutionize the lives of our children, and contribute much to building a happier world.



A handwritten signature in black ink, appearing to read 'A. V. Darzi'.

**Professor the Lord Darzi of Denham,  
PC, KBE, FRS**  
Executive Chair, WISH, Qatar Foundation  
Director, Institute of Global Health  
Innovation, Imperial College London



A handwritten signature in black ink, reading 'Richard Layard'.

**Professor the Lord Layard, FBA**  
Director, Wellbeing Programme,  
Centre for Economic Performance,  
London School of Economics

# EXECUTIVE SUMMARY

Children matter desperately – both as people and as tomorrow’s adults. Altogether, 31 percent of the world’s population is aged under 18,<sup>1</sup> representing one third of all human experience. This is the group we focus on in this report, and for convenience we shall refer to them as ‘children’.

What matters most about them is their subjective wellbeing – how they feel about their lives. This reflects a new shift of emphasis among policymakers worldwide. Increasingly people feel that the success of a society cannot be judged mainly by its level of wealth but rather by how satisfied people are with their lives.<sup>2</sup> Nearly all Organisation for Economic Co-operation and Development (OECD) countries now measure adult life satisfaction as a routine statistic,<sup>3</sup> and many are considering new forms of policy analysis with this as the objective.

Children differ hugely in their subjective wellbeing (or ‘wellbeing’ for short). There is a very wide spectrum. For much of our report we focus on those with mental disorders, who lie at the bottom end of the spectrum. But we also look at the whole spectrum because a general upward shift in wellbeing can be an excellent way to reduce the numbers at the lowest levels.

Children’s mental wellbeing is affected by every aspect of their lives – by their physical health and quality of nutrition, by their wealth and poverty, by discrimination, by war and conflict – and a whole range of other social and economic factors. But it is also affected by more personal factors. First is the family – the stability it offers, the stimulus it provides and the values it nurtures. Then there is the psychological support of the wider community, including the healthcare system, but also a whole range of local social organizations. And finally there is the school, which leaves its mark on the character of every child. In this report we cannot discuss all the factors which affect children. Instead we concentrate on the role of these more personal factors and above all on how they can be improved.

Our central focus is on how to reduce mental illness by directly addressing the personal factors that have caused or are sustaining it. This means ensuring that mental disorders are treated when they arise, but also doing our best to prevent them in the first place. Prevention requires a wide approach because there is no reliable way of predicting which children will develop mental health problems. So, when thinking about prevention, we have to think about how to improve the wellbeing of all children – a task for everyone in our society.

We need a completely new priority to be given to the wellbeing of children and we make major recommendations about what this would imply – suggestions affecting communities, healthcare systems and schools. We start with three main points.

- 1.** First, the scale of the issue. This is a massive problem. Around 10 percent of the world’s children today are suffering from diagnosable mental health problems.<sup>4</sup> Roughly half of these are suffering from anxiety disorders (or, less

commonly, depression) and a half from conduct disorder or attention deficit and hyperactivity disorder (ADHD). Approximately one percent of all children suffer from developmental disorders such as autism. Where evidence exists over time, it shows that these problems have increased over the last half century.<sup>5</sup> These children are unhappy and disturbed – the quality of their experience is very poor. And the majority of them will also become unhappy adults. The best predictor of whether a child will become a satisfied adult is not their academic achievement but their emotional health in childhood.<sup>6</sup> The cost of child mental illness is borne by all of us. Crime is increased, educational achievement thwarted and productivity diminished. Improving children’s mental health is a critical issue across the globe, and the messages of this report are as relevant to high-income countries as to those with low or middle incomes.

- 2.** Second, treatment and prevention. In the richest countries only a quarter of disturbed children get specialist help,<sup>7</sup> and in the poorest countries it is much less. In every country in the world, far fewer children are in treatment if they have mental health problems than if the problem is one of physical illness. This is shocking, because today there are really effective treatments available for children in distress, as well as the opportunity to make major changes in schools and communities that can make the problem less likely in the first place. In treatment there has been a real revolution in the last 30 years. We now have well-researched treatments for child anxiety and depression and for conduct problems, with recovery rates of over 50 percent, and with effects that are observed to persist.<sup>8</sup> We can also treat maternal depression which blights the lives of many young children. On prevention, we can use community structures and healthcare systems to promote good parenting, as well as openness and honesty about mental illness. And our schools should become as concerned with the wellbeing of children as they are with their academic performance. Because any child can develop mental health problems, we need a universal approach to mental health and wellbeing that involves the whole of society.
- 3.** Third, economics. For the sake of our common humanity we should use all the tools that are available. But it is also good economics; in most countries, mental illness is reducing gross domestic product (GDP) by over five percent.<sup>9</sup> And the net cost of the changes we propose is mostly small. Reorienting schools involves training teachers differently but not training more of them. The main cost is improved healthcare and support for parents. Intensive early intervention with at-risk families is expensive, but has been shown to save as much as it costs.<sup>10</sup> The same can be true of better treatment facilities. There should be parity of esteem between mental and physical health – children should be as likely to receive help if their problem is mental or physical. This will involve substantial gross cost. In poorer countries it will have to be done through people with less professional training than in richer countries, and with fewer of them. But the savings will be great and will often exceed the cost. We cannot afford not to do it.

In all these endeavors we have the enormous advantage of new technology – above all, the smartphone with its access to the internet. Online programs can contribute hugely to staff training, to the mental health treatment of adolescents, and to life-skills curriculums in schools. Our single most important recommendation is that one

or more major charities establish a substantial fund to design such programs to be made available free worldwide.

## Action points

This is a short report, which cannot possibly cover the whole field. So we focus on 10 specific things that can be done in every country and would bring great benefit. These action points are:

**1. Community action:** Every local community should have a local child wellbeing strategy, including an assessment of the needs of children and families, and of the role that can be played by healthcare organizations, schools, community groups, non-government organizations (NGOs), youth and faith organizations.

**2. Parity of esteem:** Evidence-based healthcare for children and their parents should be equally available whether their disorder is mental or physical.

**3. Universality:** All health professionals should be trained to identify mental health problems in children, as well as perinatal depression in mothers. They should be trained to provide general mental health education to parents and, unless more professional services are available, they should also be trained to treat these problems.

**4. Professionals:** Every country should train more professionals in evidence-based treatments, especially psychological therapy. To develop quality, there should be at least one center of excellence for every region.

**5. Schools for wellbeing:** The wellbeing of pupils should be an explicit objective of every school. Schools should have a wellbeing code (including mutual respect and anti-bullying) to which all teachers, parents and pupils subscribe. This should stress the importance of praise rather than negative criticism.

**6. Measurement:** Schools should measure pupil wellbeing regularly.

**7. A life-skills curriculum:** Schools should use evidence-based methods to provide explicit teaching in life skills for at least an hour a week throughout school life, and more in the early years. This should mainly emphasize dos rather than don'ts.

**8. Teacher training:** All teachers should be trained in ways to notice and promote child wellbeing and mental health, and to maintain a civilized learning environment.

**9. Use of mobiles:** There should be a major international program to develop free smartphone-based approaches to all our recommendations. A major international charity should be asked to support this.

**10. The sustainable development goals:** The sustainable development goals should include explicit reference to physical *and* mental health.

## To summarize

**There is a massive problem:** 10 percent of our children are suffering from a mental disorder and under a quarter of these are receiving specialist help for their problem.

**We know what to do:** For children with mental health problems, there are effective evidence-based psychological treatments which the healthcare system should provide. And every school should promote the wellbeing of its children, using evidence-based approaches.

**The net cost need not be high:** Mental illness already imposes high costs on the economy. Above all, hundreds of high-quality online programs should be developed and offered free to children and those who care for them throughout the world.

# WHY DOES CHILD WELLBEING MATTER?

A central aim of any society should be that its children and young people enjoy their lives and acquire the skills necessary to become happy, functioning adults. For this, they need to develop emotional buoyancy, coping skills, resilience and the ability to form constructive social relationships. Social and emotional capacity is a built-in response to experience. The main drivers of children's experiences are parents, teachers, health workers and the community generally. These relationships form the focus of this report. We ask how can these relationships be supported and improved to maximize good outcomes for children? And how can this be achieved given the different challenges posed in low-, middle- and high-income countries?

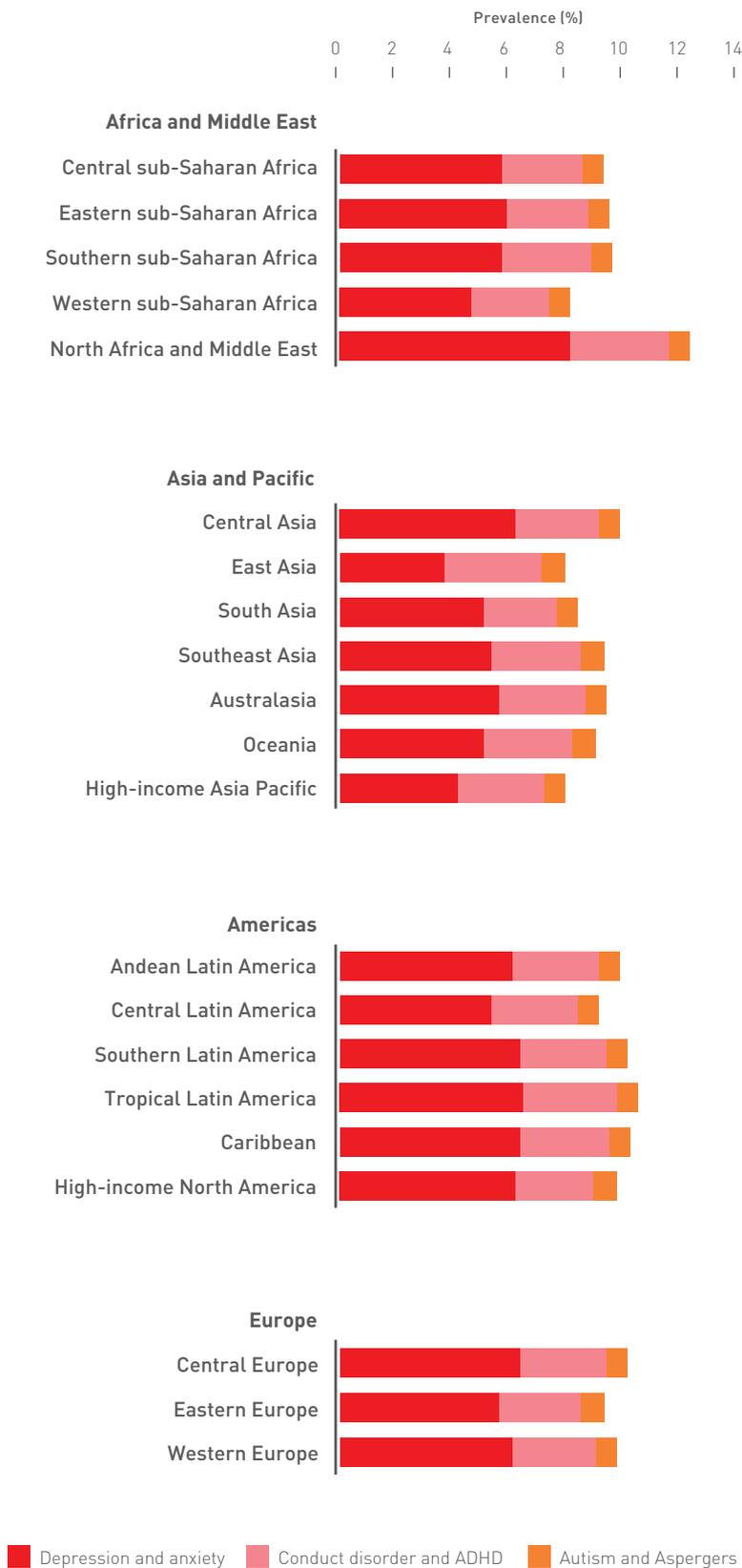
Some 31 percent of the world's population is aged under 18.<sup>11</sup> Of them, around 10 percent have a diagnosable mental disorder (mainly anxiety, depression or conduct disorder).<sup>12,13</sup> That means some 220 million children and young people. As Figure 1 shows, the problem affects every country. Of total child morbidity, the World Health Organization estimates that 23 percent results from mental rather than physical ill-health.<sup>14</sup>

This is serious enough in itself. But, on top of that, over half the children who experience mental illness in childhood will suffer from mental illness again as adults.<sup>15</sup> Their lives are more likely to be impoverished and unhappy – 90 percent of people who commit suicide are mentally ill.<sup>16</sup> Moreover, mental health affects physical health. Depression reduces life expectancy as much as smoking does.<sup>17</sup> It has a more disabling effect than arthritis, diabetes, angina or asthma.<sup>18</sup> Mental health is also crucial for a satisfied life, and research on the British Cohort Study reveals a striking finding. If you wish to predict whether a child will grow into a satisfied adult, the best predictor is not the academic achievement of the child but their emotional health.<sup>19</sup>

The suffering produced by mental illness is the main reason to care. But on top of that there is the economic cost – the sheer waste. So here are some remarkable facts.

- Adult mental illness reduces GDP by at least five percent through reduced productivity or inability to work, and through increased crime and healthcare costs.<sup>20</sup>
- If we follow up children with mental health problems into adult life, we can estimate the cost that they impose on the economy and society at large. For example, in Britain the least-happy tenth of children are seven percent poorer as adults than they would otherwise be.<sup>21</sup> This is partly because emotional problems interfere so much with their education and physical health.

Figure 1: Prevalence of mental disorders among children under 19<sup>22</sup>



- Equally, children with conduct disorder become four times more likely to commit crime, take drugs, become teenage parents, depend on welfare, and attempt suicide – as Table 1 dramatically demonstrates. It has been estimated that, in Britain, such children may cost the taxpayer in criminal justice costs an amount equal to three years’ average wages.<sup>23</sup>

**Table 1: Behavioral problems at age 7–9 predict problems in later life (New Zealand)<sup>24</sup>**

Percentage subsequently	Children whose childhood conduct was in worst 5%	Children whose childhood conduct was in best 50%
Committing violent offences (21–25)	35	3
Drug dependent (21–25)	20	5
Teenage parent	20	4
Suicide attempt (to age 25)	18	4
Welfare dependent (age 25)	33	9

- Action to reduce mental illness among children would produce major savings to society, which should be offset against the costs. For example the Incredible Years training program for parents, teachers and children, described in Box 2, produces enough healthcare savings to offset the cost of training provision.<sup>25</sup> If we add in savings to the criminal justice system, the amount saved is three times the cost.
- When the parents are mentally ill, the children suffer. Depression attacks one-fifth of all mothers, either during pregnancy or the following year.<sup>26</sup> This takes a heavy toll on mother and child. The children are more likely to develop mental health problems and to require special educational support and, as adults, they are likely to experience reduced earnings. The mother also needs more care. The average cost to society of one case of perinatal depression has been estimated in Britain to equal the average annual wage.<sup>27</sup> By contrast, the cost of successful psychological treatment (assuming a 50 percent success rate<sup>28</sup>) is only five percent of that:<sup>29</sup> the savings exceed the cost by a factor of 20 to 1. So community health workers need to screen all mothers for depression, and, as Box 3 shows, they can also be trained to deliver effective treatment in those countries where more expert specialists are not available.

These simple facts have fundamental policy implications. First, if we care about well-being, the wellbeing of children must be a top policy priority for communities and families, healthcare systems and schools.<sup>30</sup> This is a matter of basic human rights, as set out in the United Nations Convention on the Rights of the Child. And we must talk about mental health issues much more openly and destigmatize the issue. Second, if we do all of this, we shall certainly incur costs but we will also save huge expense in future. So who can do what?

## WHO CAN DO WHAT?

A fundamental principle is that it is better to intervene earlier. This applies especially if the child or its parents already have mental health problems. If problems do not resolve themselves quickly, evidence-based support should be provided to the parent, child, or both. But the principle of early intervention also applies to prevention. Supporting families is crucial. Communities need to promote good parenting practices from birth onwards. In most countries this is easiest led by the healthcare system, which is in touch with most families around the time of childbirth. That system is also best placed to detect problems of maternal depression. But education in life skills is needed throughout childhood, when schools become an increasingly important part of a child's life.

Early relationships are critical because the brain's plasticity is highest in young children and they are the most vulnerable to bad influences and the most receptive to good ones. There are marked brain differences between groups of people who have and have not been maltreated as children.<sup>31</sup> Attachment is a key capacity for a healthy emotional life. It develops early but it also continues to develop well or badly throughout childhood and adolescence.<sup>32</sup> Indeed the growth spurt in the teenage years is another key period of change and development. So we need institutions that concern themselves with child mental health from conception right through to early adulthood.

The exact institutions for delivering support will vary between countries, but there are general principles which apply everywhere. First, there needs to be an integrated approach at local level, so that no child in need slips through the net. This will involve community groups, NGOs, faith organizations and many others.<sup>33</sup> But two systems are uniquely well-placed to reach every family: the healthcare system, which is involved even before the child is born, and the school system, which every child should attend. In the sections that follow, we first review the role of the overarching community, before looking at healthcare and schools.

## Communities

Children grow up in families that are based in communities, and each community needs a framework for promoting the wellbeing of its children and families. This needs to include at least the following elements:

- Understanding the extent of the problem – what are the particular mental health needs of children in the community?
- Advice for parents on how to bring up children.
- Help for parents with mental health problems, especially perinatal depression.
- Help for parents when their children behave badly or are distressed.
- Help for children who are in distress.

- Schools that promote good values and can identify children in distress.
- Organizations that facilitate the transition to adulthood.

These functions can be performed by many types of service, but what matters is the overall pattern is adequate to the task.<sup>34</sup> Co-ordination can be provided through local government or through community leaders or ad hoc community groups, but it must happen. This can be adapted to the different local contexts, as experiments with the Communities that Care intervention in the United States (US) have illustrated. Communities that Care is a process rather than a program, providing a framework for bringing together key players in the local community to design an action plan specific to the needs of that community. Once needs are clear, a plan is drawn up that uses evidence-based programs to enhance existing services.<sup>35</sup> What is put in place will vary from one area to another, but local leadership is central to success.

**ACTION POINT 1. COMMUNITY ACTION: Every local community should have a local child wellbeing strategy, including an assessment of the needs of children and families, and of the role that can be played by healthcare organizations, schools, community groups, NGOs, youth and faith organizations.**

A good child wellbeing strategy will set out a vision for what we want, and clear actions on how we will get there. Components are likely to include:

- A forum for bringing together leaders of the key agencies dealing with families and children to ensure that everyone is aiming for the same outcomes.
- Ways of regularly assessing the need for services.
- Investment in child protection services.
- Good universal services for families, combined with specialist and targeted services for children with identified problems.
- High-quality education.
- Opportunities for positive youth experiences.
- Investment in workforce development.

It is especially challenging to cater for children who are victims of violence, yet experience of trauma is clearly related to child mental health outcomes.<sup>36</sup> Building resilience and countering the effects of living in conflict zones are critically important for the protection of children's mental health in some areas of the world.<sup>37</sup> In Box 1 we highlight one community-based approach to these problems.

## Box 1: A psychosocial care system for children in areas of violence<sup>38</sup>

This multi-tiered psychosocial care system combines mental health promotion, prevention and treatment to address the needs of at-risk children and adolescents in areas of armed conflict. Based in Indonesia, South Sudan, Sri Lanka, Burundi and Nepal, the community-based system of care is intended to:

- Increase community awareness about children's psychosocial problems (for example, a local radio program in South Sudan).
- Mobilize community resources for healing (for example, establishing child-to-child peer support networks in Burundi).
- Increase social support systems (developing so-called Child Resilience Groups – semi-structured group activities once a week for five weeks).
- Identify children in need of focused psychosocial support (using a screening instrument developed for the purpose).
- Reduce psychosocial distress (through a 15-session classroom- or community-based intervention involving structured behavioral activities to increase children's capacity to deal with problems posed by being exposed to conflict).
- Support parents of children with problems (through family-oriented psychoeducation).
- Provide individual counseling (or other treatment) to children with severe mental health problems.

All services are provided by trained teams, including community volunteers, teachers, community counselors and mental health professionals. The system is set up to ensure that children can move between the levels and components of the system, depending on need. Supervision is an integral part of the service delivery framework. The system has been successfully evaluated.

## Healthcare systems

In the provision of family support, the strongest organization in most countries is the healthcare system. It provides the main treatment for disorders when they arise, but it also has a key role in detecting disorders and in advising parents so that disorders are avoided in the first place.

In a typical country, rich or poor, roughly 10 percent of children are suffering from a diagnosable mental disorder (see Figure 1). Some five percent have behavioral disorders, sometimes accompanied by ADHD. Some five percent have mood disorders, mainly anxiety disorders, like social anxiety disorder, panic attacks, obsessive compulsive disorder, and post traumatic stress disorder, which is especially common in conflict zones (depression becomes common only in the teens.) And around one per-

cent of children have neuro-developmental disorders, like autism. As Figure 1 shows, there is no systematic pattern of difference between countries or continents. At the same time, 20 percent of mothers experience depression in pregnancy or in the year after childbirth.<sup>39</sup>

For all of these conditions there are evidence-based methods of treatment with good rates of effectiveness – many of them based on the ideas of cognitive behavioral therapy (CBT). For mild to moderate conduct disorders, the Incredible Years weekly parent training in groups for up to 24 weeks has good results, even seven years later (See Box 2).<sup>40</sup> The training has been effective in a whole range of cultures.<sup>41</sup> Fidelity to the basic ideas is crucial, but the detailed content has to be modified according to the culture and experience of the parents in the group. For severe conduct disorder, one-on-one treatments work best, but they are expensive.<sup>42</sup> And for ADHD, medication helps 75 percent of those treated to become symptom-free, but should only be used in serious cases.<sup>43</sup>

For anxiety problems, CBT yields 50–60 percent success rates in children over eight.<sup>44</sup> Depression can be treated by CBT, interpersonal therapy or, in carefully selected cases, medication – with good success rates.<sup>45</sup> And this applies also to perinatal mothers suffering from depression.<sup>46</sup>

## Box 2: The Incredible Years – training for parents of children with conduct disorder<sup>47</sup>

This is a well-known group training program for parents of children with conduct disorder, meeting weekly over 16 to 24 weeks. The emphasis is on promoting social, self-reliant child behavior and calm.

The relevant messages are introduced in a specific set of structured steps (described in a manual):

- 1.** Playing with the child, non-judgmentally, with the child leading.
- 2.** Praise.
- 3.** Authoritative rules and instructions, using eye-contact.
- 4.** Rewards and (small) punishments.

Methods include sharing filmed vignettes of parents in common parenting situations. These trigger discussions leading to interactive learning and improvements in self-management of similar situations. The emphasis given to different elements can change, depending on the parents' cultural background experiences, education, knowledge or values.<sup>48</sup>

The program has been evaluated in randomized control group trials in the US, Canada, United Kingdom (UK), Wales, Norway, the Netherlands and Portugal. Ongoing research is being done in New Zealand, Denmark, Spain, Hong Kong and Sweden. In the UK, children were followed up seven years later and found to be 80 percent less likely to have oppositional defiant disorder than those in the control group.<sup>49</sup>

The shocking thing is that, even in rich countries, most children with mental health problems get no treatment at all. In rich countries the figure is around a quarter and in poorer countries much lower.<sup>50</sup> The same is true of mothers with perinatal depression.<sup>51</sup>

This is totally in conflict with the principle of parity of esteem for mental and physical health, which means that a person has equal access to evidence-based treatment whether their disorder is physical or mental. This principle of parity of esteem is now enshrined in law in the UK and the US but there, as elsewhere, more honored in the breach than the observance. This must change.

**ACTION POINT 2. PARITY OF ESTEEM: Evidence-based healthcare for children and their parents should be equally available whether their disorder is mental or physical.**

But this is only a principle. To make it operational, we need enough suitably trained people to deliver the care. We need a framework in which children, parents and carers in need of help are identified. We also need a system that educates and supports parents to bring up children with good mental health.

The healthcare system is best placed to perform all these roles. Nearly all families interact with the system around the time of childbirth. That is the time primary care health workers identify perinatal maternal depression, and it is the time to offer parents lessons in how to bring up children who will be emotionally stable and well behaved.<sup>52</sup> Equally, as the children grow, the healthcare system is well-placed to identify if the child is developing the symptoms of mental disorders. So all healthcare workers need some basic training in identifying mental ill-health in families and in arranging suitable treatment.

But who should actually provide the treatment? The issue here is similar to that in respect of physical illness. In rich countries, we should insist on fully professional care. For example, the recovery rates from treatment by well-trained practitioners are often double or triple those from personnel who are not as well-trained.<sup>53</sup> In poorer countries, we have to use the available talent wherever we can find it. So ordinary community health workers should all be trained to deliver psychological therapy and, in many cases, it will be necessary to use non-health community workers as well.<sup>54</sup> As Box 3 shows, it can become a routine function of primary health workers to identify and treat maternal depression.

### Box 3: Treating maternal depression in rural Pakistan<sup>55</sup>

Community health workers were trained to identify and treat maternal depression, using a CBT-based intervention (the Thinking Healthy Program). The initiative used 16 home-based individual sessions and included active listening, collaboration with the family, guided discovery and homework (that is, trying things out between sessions, practicing what was learned).

Forty local areas were assigned to either intervention or routine care, with about 450 mothers in each group. At follow-up sessions (after six months) the experimental group included 23 percent still depressed, compared with 53 percent in the control group. In another study, psychoeducation is being offered to all mothers.<sup>56</sup>

In all countries, if possible, more intensive help should be offered to the most deprived young families. In the US, Nurse–Family Partnerships provide monthly visits to poor, teenage mothers for three years. Consequently their children behaved better, did better in school and earned more as adults.<sup>57</sup> A similar program in Jamaica is described in Box 4.

### Box 4: Psychosocial stimulation to growth-stunted toddlers in Jamaica<sup>58</sup>

In weekly visits over a two-year period, community health workers taught parenting skills and encouraged mothers and children to interact in ways that develop cognitive and socio-emotional skills. Children were randomized into the trial and 20 years later were found to be earning 25 percent more than those from the control group. Children in the program were also found to score more highly on cognition, psychosocial skills and schooling attainment as well as showing reduced participation in violent crime.<sup>59</sup>

In every country there should also be a major expansion in higher level mental health specialists, especially psychological therapists. England's Improving Access to Psychological Therapies (IAPT) program shows how child mental health services can be quite quickly transformed to deliver evidence-based therapies with measurable outcomes.<sup>60</sup> To promote change, there has to be a center of excellence in every region, which acts as a hub of training and research and demonstrates good practice. This is as true for poorer countries as it is for richer parts of the world. The quality in such centers can set the tone for the whole system. And they must do research that is relevant to their local problems. Mental health research is grossly underfunded and, within that, child mental health is especially underfunded. That should change. We need more research on treatments but also much more research on prevention.

So from this discussion emerge two main action points:

**ACTION POINT 3. UNIVERSALITY:** All health professionals should be trained to identify mental health problems in children, as well as perinatal depression in mothers. They should be trained to provide general mental health education to parents and, unless more professional services are available, they should also be trained to treat these problems.

**ACTION POINT 4. PROFESSIONALS:** Every country should train more professionals in evidence-based treatments, especially psychological therapy. To develop quality, there should be at least one center of excellence for every region.

## Schools

Every parent wants their child to be happy at school and to learn how to become a happy adult. Yet many schools do not see this as a primary objective of their institution. Increasingly in many countries, schools are becoming exam factories. To improve child wellbeing, this must be reversed, and schools must address the emotional and spiritual needs of their children as well as their intellectual development.

There is no conflict between these objectives. In fact, the evidence is clear – that, if children are happier, that is also good for their intellectual development. For example, in a survey of 200 school-based programs to promote the social and emotional skills of children, it was found that children taking these programs gained about 10 percentile points in emotional wellbeing and behavior but also in academic achievement.<sup>61</sup> Conversely, low wellbeing is linked with worse performance at school. For example, children with emotional or behavioral difficulties are more likely to be excluded from school and to leave school without qualifications.<sup>62</sup>

So schools should make the wellbeing of their children a major objective, and this should include the children's sense of social obligation and also how they feel inside: are they fulfilled or are they anxious or depressed? Every school should have a wellbeing policy, affecting the whole life of the school. There is good evidence that schools with such a policy improve their outcomes on all fronts.<sup>63</sup> A wellbeing policy should include at least three elements:

- A code of behavior (including an anti-bullying procedure<sup>64</sup>).
- A system of measuring wellbeing.
- Explicit teaching of life skills.

**ACTION POINT 5. SCHOOLS FOR WELLBEING:** The wellbeing of pupils should be an explicit objective of every school. Schools should have a wellbeing code (including mutual respect and anti-bullying) to which all teachers, parents and pupils subscribe. This should stress the importance of praise rather than negative criticism.

The wellbeing code should be designed in consultation with teachers, parents and children, all of whom should explicitly subscribe to it (in some ceremony and/or in writing). As Box 5 suggests, it should cover the basic values (of, for example, mutual respect) to be applied to all relationships. It should also cover the procedures to be applied when the code is infringed. But the fundamental aim in teacher–pupil relationships (as in parent–child relationships) should be to use praise and positive incentives rather than violence or harshness.<sup>65</sup> Children should be encouraged always to live up to the standards of their better selves.<sup>66</sup>

## Box 5: An illustrative school wellbeing code

### **Our aims**

- Our aim is to promote the happiness of every child, and equip each child to become a happy adult who contributes to the happiness of others.
- We also aim to develop academic competence and above all a love of learning. But this is easier to achieve if a child is happy.

The two aims are thus complementary and not in competition.

### **To achieve our aims, we will ensure that:**

- All members of the school (teachers, parents and children) treat each other with respect, using encouragement and praise rather than violence or criticism as the chief form of incentive.
- Bullying of one child by another is unacceptable and we have clear procedures for identifying it and dealing with it.
- We have explicit systems for developing values in our children, such as adopting one value as the ‘value of the month’, for example caring, trust, honesty, courage.
- Our aims are fully reflected in all school activities, including assemblies.
- All teachers are comfortable talking about values and the necessity of developing good values and good habits throughout a child’s life at school.
- We draw strongly on the evidence of what programs work best for developing specific life skills and devote at least one hour a week to evidence-based teaching of life skills throughout the school life.
- All our teachers are able to talk openly and positively about problems of mental health and identify and get support for those needing help.

If you treasure it, measure it. If schools do not measure the wellbeing of their children but do measure their intellectual development, the latter will always take precedence. We would therefore suggest that schools use standard questionnaires to

measure the wellbeing of their children, preferably each year and certainly when they enter and leave the school. If the resulting scores are properly standardized, the change in wellbeing will be a good measure of the wellbeing value added during school life.

The questionnaires used will also help schools to recognize those of their children who are experiencing difficulties which might not otherwise be identified.

While children's behavior is easy to see, their inner world is much less so. If we assess children's physical health when they go to school, it is surely wrong if we do not also assess their mental health. And, if a child is in distress, they should be offered help from a person with special competence in mental health. One possible questionnaire is illustrated in Table 2.

**ACTION POINT 6. MEASUREMENT: Schools should measure pupil wellbeing regularly.**

Schools need an ethos that promotes children's wellbeing and identifies children who are languishing; but they should also devote at least an hour a week to education in life skills. Children and young people need to learn how to understand and manage their own emotions, understand others and care for them, manage their sexual relationships responsibly, eat and drink sensibly and avoid drugs, understand mental disorders and what can be done about them, understand parenting, manage their responses to modern media and choose positive life goals.

There are now hundreds of programs that have been developed worldwide to address one or more of these issues. Many of these programs have been rigorously evaluated on the whole age cohort in a school and been found to produce good results, at least in the short run. This was the finding of Durlak et al that we quoted earlier,<sup>67</sup> and it related to impacts in the first six months after the programs ended. But, in the few cases where children have been followed up over a longer period, the effects have often been found to fade over time and, in many cases, to disappear.<sup>68</sup> This is not surprising given that the programs typically average 20 hours. We should also note that many quite famous programs have had at least one trial which found no effects.<sup>69</sup>

This leads to two important conclusions. First, if children are to develop good life skills, they need more than one or two 20-hour programs: they need a whole curriculum of life skills, at least once a week throughout the school life. As Aristotle observed, good habits are learned through interesting repetition in varying contexts. Second, this curriculum should be evidence-based and depend as little as possible on inspired improvisation by the teacher. It is universally found that the best results follow from using detailed materials accompanied by a good manual on how to use them and some explicit training of the teachers<sup>70</sup> (this is not so different from what is needed for a good surgical operation.) And the best results always come from offering a positive vision rather than warnings about what not to do.

Table 2: An illustrative way of measuring wellbeing in children aged 13 and over (the Warwick-Edinburgh Mental Wellbeing Scale)<sup>71</sup>

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks

Statements	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	1	2	3	4	5
I've been feeling useful	1	2	3	4	5
I've been feeling relaxed	1	2	3	4	5
I've been feeling interested in other people	1	2	3	4	5
I've had energy to spare	1	2	3	4	5
I've been dealing with problems well	1	2	3	4	5
I've been thinking clearly	1	2	3	4	5
I've been feeling good about myself	1	2	3	4	5
I've been feeling close to other people	1	2	3	4	5
I've been feeling confident	1	2	3	4	5
I've been able to make up my own mind about things	1	2	3	4	5
I've been feeling loved	1	2	3	4	5
I've been interested in new things	1	2	3	4	5
I've been feeling cheerful	1	2	3	4	5

\* Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved. [www2.warwick.ac.uk/fac/med/research/platform/wemwbs/](http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/)

The obvious way forward is to draw on the most successful programs worldwide and to combine them into a single curriculum. For 11- to 14-year-olds, Table 3 illustrates such a curriculum that is being trialed in the Healthy Minds experiment in 34 English schools.<sup>72</sup> Mindfulness training will be used as a standard practice in every session, since it has already established itself as a reliable way in which children can calm themselves and improve their wellbeing.<sup>73</sup>

**Table 3: A weekly life-skills curriculum for 11- to 14-year-olds (Healthy Minds)<sup>74</sup>**

Topic	Program used
Resilience	Penn Resilience Program; <sup>75</sup> MoodGym <sup>76</sup>
Compassion	Relationship Smarts
Sexual relationships	SexEd Sorted
Drugs	Unplugged
Eating and alcohol	SHAHRP <sup>77</sup>
Mental disorders	Science of Mental Illness <sup>78</sup>
Parenting	Parents under Construction <sup>79</sup>
Media awareness	Media Navigator
Life goals	Schools to Life
Mindfulness	Breathe <sup>80</sup>

For primary age children, the most respected curriculum of social and emotional learning is that provided by the Promoting Alternative Thinking Strategies (PATHS) program, which includes 130 lessons over a one-year period.<sup>81</sup> Another admirable program which aims to develop moral sense and pro-social behavior is the Good Behavior Game where children in a primary school class are divided into teams and each team is scored according to the number of times a member of the team breaks one of the behavior rules. If there are fewer than five infringements, *all* members of the team get a reward. Children in the treatment and control groups were followed right up to age 19–21, and those in the treatment group had significantly lower use of drugs, alcohol and tobacco, and significantly lower frequency of anti-social personality disorders.<sup>82</sup>

Incredible Years also has a child-training program for primary age young children, called the Incredible Years Dinosaur Social and Emotional Curriculum. It has been successfully evaluated both as a small group treatment program for young children with conduct problems and ADHD, as well as an indicated prevention program for high-risk children in schools that address high levels of families living in poverty.<sup>83</sup>

One finding from all these programs is that the children who benefit most are, on average, those who start off with the greatest problems. But this is not an argument for targeted intervention. That would involve an unacceptable degree of stigma and exclude many others who stand to gain. Also, the programs are not expensive, once teachers have been trained, they involve little extra expense – they become parts of the school curriculum.

**ACTION POINT 7. A LIFE-SKILLS CURRICULUM: Schools should use evidence-based methods to provide explicit teaching in life skills for at least an hour a week throughout school life, and more in the early years. This should mainly emphasize dos rather than don'ts.**

Whether they teach life skills or not, all teachers should have basic training in how to promote child wellbeing and identify mental health problems in children. As suggested in Table 2, there are already easy-to-complete short questionnaires that teachers can use to identify young people who are struggling with high levels of psychological difficulties. In teacher-child relationships, the same principles apply as in parent training: the importance of praise and of calm. These things can be learned by teachers in well-designed programs lasting five to eight days (see Box 6). This results in better-behaved children and a better learning environment.<sup>84</sup>

**ACTION POINT 8. TEACHER TRAINING: All teachers should be trained in ways to notice and promote child wellbeing and mental health, and to maintain a civilized learning environment.**

### Box 6: Training teachers to improve children's conduct in Jamaica<sup>85</sup>

Teachers in 12 community preschools were given eight days training in an adapted version of the Incredible Years teacher training program, using the principles of praise and calm. The participating schools were randomly selected from 24 schools, with another 12 acting as control groups. In all 24 schools, three children were followed in each class (those with the worst pre-trial conduct). Following the trial, children's observed classroom behavior, teacher-reported and parent-reported behavior all improved significantly in schools using the program, relative to the control groups. School attendance also improved.

## MOBILIZING THE MOBILE

To implement all our recommendations, one of the most effective ways will be to harness the power of cheap, ubiquitous mobile telephone technology. In many low- and middle-income countries there may still be limited access to personal computers or landline telephones, but the majority of the world's young people have access to mobile telephones.<sup>86</sup> And they love them. As the power of each generation of telephones increases exponentially, these phones are evolving into personal hand-held computers.

Year-on-year, access to information and communication technologies continues to grow. In 2013, nearly all of the world's population had access to a mobile cellular signal, and around 40 percent had access to mobile broadband.<sup>87</sup> The number of mobile subscriptions in use worldwide grew from fewer than 1 billion in 2000 to over 6 billion in 2011, of which nearly 5 billion were in low- and middle-income countries.<sup>88</sup> The UN estimates that more people have access to a cell phone than a toilet (6 billion compared with 4.5 billion respectively).<sup>89</sup> Mobile telephone apps are becoming widespread; 30 billion were downloaded in 2011 and this figure will go on rising.

There are well-known dangers associated with the internet – online bullying, premature exposure to adult sexuality and so on. But the internet also offers a huge opportunity to bring to billions of children and their parents and teachers tools which can transform their mental health. There are already exciting examples of wellbeing interventions that can be delivered online or through mobile telephone apps<sup>90</sup> (see Boxes 7 and 8). Not all programs work, and most work best when there is some human contact as well. But we firmly believe that this is an important part of the way forward, and that a concerted effort to develop new approaches using this technology is needed.

To make this happen rapidly requires a major co-ordinated effort. This could usefully be led by one or more major international charities. It is highly desirable that the resulting products become available worldwide free of charge – the intellectual property of the world. To develop such free products would require significant charitable money. It is hard to think of a more deserving cause than the wellbeing of children worldwide.<sup>91</sup>

**ACTION POINT 9. USE OF MOBILES: There should be a major international program to develop free smartphone-based approaches to all our recommendations. A major international charity should be asked to support this.**

## Box 7: A computerized CBT game to treat depression (SPARX)<sup>92</sup>

In the online game SPARX, the young person chooses an avatar and, facing a series of challenges, learns how to restore balance in a fantasy world dominated by GNATS (Gloomy Negative Automatic Thoughts). The computerized program has seven modules and involves no significant contact with clinicians. It has been trialed on 94 New Zealand adolescents seeking help for depression, with an equal number randomized to face-to-face counseling. Remission rates were 44 percent in the CBT group and 28 percent for the control group.

## Box 8: A computerized CBT program for anxiety (Cool Teens)<sup>93</sup>

Cool Teens is a game on CD-ROM that consists of eight, half-hour modules which young people undertake, together with a weekly 15-minute call to a therapist. Compared with a randomized control group on a waiting list, the average participant lost at least one anxiety disorder.

# CONCLUSION

We hope to have shown that:

- Children's wellbeing and mental health is desperately important, and there are high levels of untreated problems.
- We have good evidence-based ways to improve this.
- The cost of doing so is manageable, since so many other costs are saved.

The key principles are early intervention to support families, parity of treatment within the healthcare system, and children's wellbeing being included as a major objective for schools.

These issues are moving up the political agenda, but far too slowly. Two things could make a real difference:

- Mental health should appear explicitly in the post-2015 sustainable development goals.
- Countries could have a Cabinet Minister for Mental Health.

If something is really important, it should be reflected in our policymaking structures. We cannot continue as if academic success is almost all that matters for a child.

**ACTION POINT 10. THE SUSTAINABLE DEVELOPMENT GOALS: The sustainable development goals should include explicit reference to physical *and* mental health.**

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